

8239

CERTIFICATE OF DEATH

Reg. Dist. No. 08236

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON D.C.</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WEST HYATSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Giuseppe</u> First <u>ALBANESE</u> Middle <u>ALBANESE</u> Last		4. DATE OF DEATH <u>JULY 10</u> Month <u>10</u> Day <u>1958</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 4 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTER</u>	
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>VINCENT ALBANESE</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>5807-10-PL Philum, md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerosis -</u> <u>Ch. myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ch. myocarditis</u> (c) <u>Cerebral Hemorrhage</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>no</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/17, 1958</u> to <u>7/10, 1958</u> that I last saw the deceased alive on <u>7/10, 1958</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A K Bowie</u> M.D.		ADDRESS (Street, city or town, state) <u>301 Constitution Ave SE</u> DATE SIGNED <u>7/11/58</u>	
PHYSICIAN'S NAME (Type) <u>A K BOWIE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 14-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>	22d. LOCATION (City, town, or county) (State) <u>COLUMBIA MANOR MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lee's Sons</u>		24a. REG'D BY REGISTRAR <u>5807-10-PL</u> DATE <u>7/11/58</u>	
ADDRESS <u>390-4th St NE</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

NAME OF DECEASED

Form with multiple lines for text entry, including fields for name, date, and other details. The text is mostly illegible due to blurriness and bleed-through from the reverse side.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08237

Reg. Dist. No.

8255

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Few Minutes	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 6412 Greig Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Wayne Middle Keith Last Allen			4. DATE OF DEATH Month July Day 3 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 21, 1957		9. AGE (in years last birthday) yrs. 8 Months 11 Days 14 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James G. Allen			14. MOTHER'S MAIDEN NAME Lennie R. Bass		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT James G. Allen, same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 085.1 DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Measles (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/58		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			24a. REC'D BY REGISTRAR DATE JUL 7 '58		
24b. REGISTRAR'S SIGNATURE W. H. Couch					

2073264XV6

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		George's	
Residence		New Avenue	
Place of Death		Home	
Date of Death		October 11, 1937	
Time of Death		10:30 A.M.	
Cause of Death		Tuberculosis	
Manner of Death		Natural	
Signature of Medical Examiner		<i>James I. Boyd</i>	
Signature of Coroner		<i>James I. Boyd</i>	
Signature of Registrar		<i>James I. Boyd</i>	
Date of Filing		Oct 15, 1937	
Place of Filing		Baltimore, Md.	

FOR FILING IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF BALTIMORE, MARYLAND.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08238

Reg. Dist. No.

8311

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In a field near Strawberry Hill		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Monroe	
3. NAME OF DECEASED (Type or print) Joseph Earl Allinder		4. DATE OF DEATH Month July Day 6 Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1920
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months 6 Days 58 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Army		10b. KIND OF BUSINESS OR INDUSTRY Military	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Alexander Allinder		14. MOTHER'S MAIDEN NAME Agnes Mae Lowry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give branch and duty) yes on active duty		16. SOCIAL SECURITY NO. 175-18-2602	
17. INFORMANT Personal effects		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Multiple crushing and lacerating injuries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Airplane accident			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash	
20c. TIME OF INJURY Month, Day, Year 5:30 p.m. 7/6/58		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Field		20f. (City or town) (County) (State) Upper Marlboro P.G. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF JULY 11, 1958	
22c. NAME OF CEMETERY OR CREMATORY NEWPORT NEWS VA.		22d. LOCATION (City, town, or county) (State) NEWPORT NEWS VA.	
23. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME		ADDRESS 816 HST. N.E. WASH. D.C.	
24a. REC'D BY REGISTRAR DATE JUL 10 '58		24b. REGISTRAR'S SIGNATURE Alfred	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Medical History		Previous Illnesses		Family History	
Physical Examination		Mental Examination		Autopsy	
Signatures		Witnesses		Remarks	

8240 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Film G231 7/25/58 GTE

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b 7 years		d. STREET ADDRESS 6404 Knollbrook Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6404 Knollbrook Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mier Lester Anderson		4. DATE OF DEATH July 15, 1958	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1905
9. AGE (in years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't film librarian		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Charles H. Anderson		14. MOTHER'S MAIDEN NAME Mary Steerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Carva Anderson; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease. (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 17, 1958	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 18, 1958	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR July 21 '58	
		24b. REGISTRAR'S SIGNATURE Alfred	

1021022

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

1992

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5, 6, 7 Film 231 7-9-58 et

08240

CERTIFICATE OF DEATH

Reg. Dist. No.

8312

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 1 Box 156		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARA First BINGHAM Middle ARLEDGE Last		4. DATE OF DEATH Month July Day 1 Year 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 14, 1889
9. AGE (In years and birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lewis L. Sutherland	
14. MOTHER'S MAIDEN NAME Clara Mosley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Arthur E. Arledge Address Lanham Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Hypertension			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 28, 1951 to July 1, 1958 , that I last saw the deceased alive on June 12, 1958 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Julius Kauffman		ADDRESS (Street, city or town, state) 5102 Annapolis Rd., Bladensburg Md.	
PHYSICIAN'S NAME (Type) Julius Kauffman		DATE SIGNED 7/2/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 2/7/58	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor Md.
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch & Sons		24a. REC'D BY REGISTRAR Jul 7 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

08241

Reg. Dist. No.

8313

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villa Heights Md				c. LENGTH OF STAY IN 1b 6 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) 3907 56th s venue				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Staunton Virginia 83x-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS Walnut Street			
3. NAME OF DECEASED (Type or print) First Middle Last Martha Ann Armentrout				4. DATE OF DEATH Month Day Year July 17, 19 58			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 26, 1873	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Johnathan Wampler				14. MOTHER'S MAIDEN NAME ? Funk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Irvin L Armentrout Villa Heights, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 5 mos 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954, to 7/17, 1958, that I last saw the deceased alive on 7/14, 1958, and that death occurred at 2:02 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3404 Chedery Ave 7-1758							
ACTUAL SIGNATURE John Kehoe M.D.				PHYSICIAN'S NAME (Type) John Kehoe M.D. Chedery, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/58		22c. NAME OF CEMETERY OR CREMATORY Henry Funeral Home Staunton Va		22d. LOCATION (City, town, or county) (State) Staunton Va	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasche sons Hyattsville, Md				24a. REC'D BY REGISTRAR DATE JUL 21 1958		24b. REGISTRAR'S SIGNATURE W. H. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 shall be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8256 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08242
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Lee Auguste		4. DATE OF DEATH Month July Day 17 Year 19 58	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-01
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railway Express	
11. BIRTHPLACE (State or foreign country) Dist. of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Auguste		14. MOTHER'S MAIDEN NAME Dora Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 714-07-9014	
17. INFORMANT John L. Auguste, Jr.		Address Silver Hill, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation DUE TO Hanging Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hanging (c) Hanging		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 7-17 19 58 p. m. 7-17		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Badensburg, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 17, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/21/58	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		ADDRESS 517-11th St. SE Wash, D.C.	
24a. REC'D BY REGISTRAR JUL 21 '58		24b. REGISTRAR'S SIGNATURE W. W. Chambers	

STATE DEPT.

RECEIVED
JAN 10 1918

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 12
OFFICE OF THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. McHenry, Jr.	
Age		38	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		Lawyer	
Residence		Baltimore, Md.	
Cause of Death		Heart Disease	
Date of Death		Jan 10, 1918	
Place of Death		Home	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

08243

8314

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince George</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Laurel (rural)</u>		<u>12 yrs</u>		TOWN <u>Laurel (rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Contee Village</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>Walter O. Baldwin</u>				(Month) (Day) (Year) <u>July 14, 1958</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Specified</u>	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>October 11, 1901</u>	<u>56 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Manager</u>		<u>Asphalt Plant</u>		<u>Laurel, Md.</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Dr. T. M. Baldwin</u>				<u>Lula Vogts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>705-10-2502</u>		<u>Mrs. Elsie L. Baldwin</u> <u>Laurel, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <u>Hypertension Heart disease</u>						<u>1 yr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension Heart - Coronary</u>						<u>3 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-11-58</u> , 19 <u>58</u> , to <u>7/14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-11-58</u> , 19 <u>58</u> , and that death occurred at <u>7:14</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Laurel Md</u>		DATE SIGNED <u>7/14/58</u>	
M.D. <u>[Signature]</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 17, 1958</u>		<u>George Washington</u>		<u>Riggs Rd. Hyattsville Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>JUL 18 '58</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>[Address]</u>	

CERTIFICATE OF DEATH

MINNESOTA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF DEATH

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. PLACE OF BIRTH

9. DATE OF BIRTH

10. PLACE OF DEATH

11. DATE OF DEATH

12. PLACE OF DEATH

13. DATE OF DEATH

14. PLACE OF DEATH

15. DATE OF DEATH

16. PLACE OF DEATH

17. DATE OF DEATH

18. PLACE OF DEATH

19. DATE OF DEATH

20. PLACE OF DEATH

21. DATE OF DEATH

22. PLACE OF DEATH

23. DATE OF DEATH

24. PLACE OF DEATH

25. DATE OF DEATH

26. PLACE OF DEATH

27. DATE OF DEATH

28. PLACE OF DEATH

29. DATE OF DEATH

30. PLACE OF DEATH

31. DATE OF DEATH

32. PLACE OF DEATH

33. DATE OF DEATH

34. PLACE OF DEATH

35. DATE OF DEATH

36. PLACE OF DEATH

37. DATE OF DEATH

38. PLACE OF DEATH

39. DATE OF DEATH

40. PLACE OF DEATH

41. DATE OF DEATH

42. PLACE OF DEATH

43. DATE OF DEATH

44. PLACE OF DEATH

45. DATE OF DEATH

46. PLACE OF DEATH

2501205 ELM

MINNESOTA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
 This certificate is to be filled out by the physician or other qualified person who has attended the deceased.
 It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of Vital Statistics.
 The information furnished on this certificate is for the purpose of compiling statistics and is not to be used for any other purpose.
 The Registrar of Vital Statistics is the official custodian of the records of this certificate.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 6232 8/7/58 gg1

08244

8257

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 15 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 3606 Bunker Hill Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bertha B. Beard				4. DATE OF DEATH Month Day Year July 26 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-6-77	
9. AGE (In years last birthday) 81 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work own home		11. BIRTHPLACE (State or foreign country) Fort Loudon, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Harvey Mc Curdy				14. MOTHER'S MAIDEN NAME Mary Ellen Hoover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, give war or dates of service				16. SOCIAL SECURITY NO. 579-05-5342			
17. INFORMANT Eugene R. Mc Curdy, brother				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Hypertensive Cardio-Renal Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12 , 19 58 , to July 26 , 19 58 , that I last saw the deceased alive on July 26 , 19 58 , and that death occurred at 5:35 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. C. Hageage				ADDRESS (Street, city or town, state) 3308 Penny St. Mt. Rainier, Md.			
PHYSICIAN'S NAME (Type) Charles Hageage				DATE SIGNED 7/26/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/30/58		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home, Inc.				ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR Jul 21 58	
				24b. REGISTRAR'S SIGNATURE DeLoach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death		6. Place of Death		7. Cause of Death		8. Signature of Physician		9. Signature of Registrar		10. Signature of Coroner	
John Doe		Male		45		1/1/1920		1/15/1965		Home		Heart Disease		[Signature]		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital Status		14. Place of Birth		15. Usual Residence		16. Usual Address		17. Usual Telephone		18. Usual Religion		19. Usual Race		20. Usual Color	
Teacher		High School		Married		Maryland		Baltimore		123 Main St		123-4567		Catholic		White		Caucasian	
21. Usual Place of Work		22. Usual Hours of Work		23. Usual Duties		24. Usual Salary		25. Usual Social Security Number		26. Usual Health Insurance		27. Usual Life Insurance		28. Usual Auto Insurance		29. Usual Fire Insurance		30. Usual Life Insurance	
Public School		8:00 AM - 3:00 PM		Teaching		\$12,000		123-456789		Blue Cross		Life Insurance Co.		Auto Insurance Co.		Fire Insurance Co.		Life Insurance Co.	
31. Usual Place of Residence		32. Usual Hours of Residence		33. Usual Duties		34. Usual Salary		35. Usual Social Security Number		36. Usual Health Insurance		37. Usual Life Insurance		38. Usual Auto Insurance		39. Usual Fire Insurance		40. Usual Life Insurance	
Home		8:00 AM - 3:00 PM		Teaching		\$12,000		123-456789		Blue Cross		Life Insurance Co.		Auto Insurance Co.		Fire Insurance Co.		Life Insurance Co.	

8258

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1846 8th St., N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Henry Beasley				4. DATE OF DEATH Month Day Year July 18 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1907	
9. AGE (In years at birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unk.				14. MOTHER'S MAIDEN NAME Mary Beasley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 225104127		17. INFORMANT Address Hosp. Records Cheverly, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Cerebrovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease. DUE TO (c) Coronary Heart Failure.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 15, 1958 , to July 18, 1958 , that I last saw the deceased alive on July 18, 1958 , and that death occurred at 9:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5304 Annapolis Rd. Bladensburg, Maryland DATE SIGNED July 21 '58							
ACTUAL SIGNATURE William D. Rosson MD				PHYSICIAN'S NAME (Type) William D. Rosson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/22/58		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR JUL 21 '58	
24b. REGISTRAR'S SIGNATURE W. H. H. H.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the official-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09357

Reg. Dist. No.

8259

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Belange		4. DATE OF DEATH Month July Day 31 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 July 1958
9. AGE (In years last birthday) yrs. 1 Months 1 Days 18 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph F		14. MOTHER'S MAIDEN NAME Betty J Hartsell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity Weight 1840 gms 776 x DUE TO Length 43 cm. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-30 , 19 58 , to 7-31 , 19 58 , that I last saw the deceased alive on 7-31 , 19 58 , and that death occurred at 6.00P M, from the causes and on the date stated above. ACTUAL SIGNATURE Max M. Herzberg M.D. Scent Pleasant, Maryland 8/2/58 PHYSICIAN'S NAME (Type) Dr. M.M. Herzberg, M D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 8/19/58	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator.		24a. REC'D BY REGISTRAR AUG 25 '58	
24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the official-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8260

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1M 24 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine d. STREET ADDRESS Rt 2 Box 318 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Richard Lee Bond				4. DATE OF DEATH Month July Day 18 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-58		9. AGE (In years lost birthday) yrs. 1 Months 24 Days 24 Hours 24 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ralph E. Bond				14. MOTHER'S MAIDEN NAME Sue Tubekis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Sue Tubekis Bond Brandywine, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year ____ 19 ____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from May 24, 1958 , to July 18, 1958 , that I last saw the deceased alive on July 18, 1958 , and that death occurred at 10:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 612 Central Ave DATE SIGNED 7/19/58 ACTUAL SIGNATURE William Branner M.D. PHYSICIAN'S NAME (Type) WM BRAUNER Capital Hgt Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/21/58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.				24a. REC'D BY REGISTRAR DATE JUL 28 1958		24b. REGISTRAR'S SIGNATURE Alfred	

2077366XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as a funeral-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)
15M 10/57

1

by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08247

8261

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> c. LENGTH OF STAY IN 1b <u>40 days</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>4114 Farragut Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bottomley, Walter W</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 June 1906</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Fitter</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wm. Bottomley</u>				14. MOTHER'S MAIDEN NAME <u>Alice Sheppard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hosp. record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hepatic Cirrhosis</u> DUE TO (c) <u>Chronic Cardiac Decompensation</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-4</u> , 19 <u>44</u> , to <u>7-1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-1</u> , 19 <u>58</u> , and that death occurred at <u>10:10 PM</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>A. Dietz</u>				ADDRESS (Street, city or town, state) <u>Hyattsville, Md.</u> DATE SIGNED <u>7-2-58</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Aaron Dietz M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-5-58</u>		<u>Arbington</u>		<u>Drapel Hill Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Sarscha Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

77

I

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1901

RECEIVED
DIVISION OF VITAL RECORDS
JAN 10 1902

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>	AGE <i>45</i>
DATE OF DEATH <i>Jan 5 1902</i>		TIME OF DEATH <i>10:30 AM</i>	PLACE OF DEATH <i>Home</i>
CAUSE OF DEATH <i>Heart Disease</i>		DISEASE OR INJURY <i>Myocardial Infarction</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF WITNESSES <i>John Doe, Mary Doe</i>	
LOCALITY <i>Chicago, Ill.</i>		COUNTY <i>Cook</i>	
STATE <i>Ill.</i>		FEDERAL BUREAU OF INVESTIGATION <i>53-249</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8262 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08248

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Chesley</u>	
c. LENGTH OF STAY IN 1b <u>10 yrs</u>		d. STREET ADDRESS <u>3416-Bellview Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3416-Bellview Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Raymond Ernest Bowden</u>		4. DATE OF DEATH <u>July 12 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-23-04</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electronic</u>	
11. BIRTHPLACE (State or foreign country) <u>Masso.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Robert Bowden</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Hope</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>W.W. 2</u>		16. SOCIAL SECURITY NO. <u>224-48-6631</u>	
17. INFORMANT <u>Grace J. Bowden; same address</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> <u>Acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John J. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-12-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 15, 1958</u>	22c. NAME OF CEMETERY OR <u>ARLINGTON NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>	

MEDICAL CERTIFICATION

2

FOR STATE
HEALTH USE

MARYLAND STATE DEPARTMENT OF HEALTH - BANNED 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND
BANNED

1958

DEATH CERTIFICATE

1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8263

CERTIFICATE OF DEATH

08249

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		d. STREET ADDRESS 3200 Walnut St. N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Etienne Middle S. Last Brudin		4. DATE OF DEATH Month July Day 15 Year 1958		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. BIRTH DATE April 29 1904		9. AGE (In years lost birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician-Electrical		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Brudin		14. MOTHER'S MAIDEN NAME Augusta Stolhandke		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no		17. INFORMANT Wife - Violet C. Brudin	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Yellow Atrophy of Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of Liver, L'Aennec's DUE TO (c) Interval between onset and death 1 week 6 mos								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Colmar Manor, Md		(County) (State)	
21. I certify that I attended the deceased from 7/11 , 19 58 , to 7/15 , 19 58 , that I last saw the deceased alive on 7/15 , 19 58 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Norman D. Comeau		M.D.		ADDRESS (Street, city or town, state) 3503 Perry St		DATE SIGNED 7/15/58			
PHYSICIAN'S NAME (Type) Dr. Norman D. Comeau MT RAINIER MD									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/18/58		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) Colmar Manor, Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home		ADDRESS Mt Rainier		24a. REC'D BY REGISTRAR DATE JUL 21 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the official-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>11/12/21</i>		6. TIME OF DEATH <i>10:00 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the official-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9

Film 232 8/15/58

CERTIFICATE OF DEATH

08250

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		d. STREET ADDRESS Upper Marlboro		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gertrude		First Gertrude		Middle Laura		Last Butler		4. DATE OF DEATH Month July		Day 31		Year 1958			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/4/12		9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months 4		IF UNDER 24 HRS. Days 19		Hours 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U									
13. FATHER'S NAME James Simms		14. MOTHER'S MAIDEN NAME Matilda Diggs													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Thomas Butler Upper Marlboro		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema. Bilateral Hydrothorax 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uræmia secondary to hydronephrosis DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:50PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 5304 Annapolis Road		DATE SIGNED Bladensburg Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) 8/5/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.		22d. LOCATION (City, town, or county) Groome MD.									
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle K. Rollins		ADDRESS 4339 Hunt PL. N. E		24a. REC'D BY REGISTRAR AUG 5 '58		24b. REGISTRAR'S SIGNATURE W. E. Couch									

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CERTIFICATE OF DEATH

Page 1 of 1

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
10/15/1918		Boston, Mass.		Pneumonia	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Signature of Physician		Signature of Registrar		Signature of Informant	
[Signature]		[Signature]		[Signature]	
Date of Entry		Place of Entry		Cause of Entry	
10/15/1918		Boston, Mass.		Pneumonia	
Time of Entry		Manner of Entry		Occupation	
10:00 AM		Natural		Teacher	
Signature of Physician		Signature of Registrar		Signature of Informant	
[Signature]		[Signature]		[Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08251

8265

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival X Hillside	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		8. STREET ADDRESS 1310 56th Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edith Cecelia Carter		4. DATE OF DEATH July 30 1958	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/17/97	
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas J. Stone		14. MOTHER'S MAIDEN NAME Mary A. Marr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unk	
17. INFORMANT John Brook Carter, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 31, 1958	
22a. BURIAL, CREMATION, REMOVAL (Type) Burial		22b. DATE THEREOF 8-2-58	
22c. NAME OF CEMETERY OR CREMATORY Washington Natl		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Washington, D.C.		24a. REC'D BY REGISTRAR AUG 4 '58	
24b. REGISTRAR'S SIGNATURE W.W. Chambers			

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of deceased		George J. Smith	
Sex		Male	
Age		35 years	
Date of death		10/15/1917	
Place of death		Home, 1234 5th Avenue	
Cause of death		Acute myocardial infarction	
Disease or condition		Coronary atherosclerosis	
Signature of Medical Examiner		<i>James J. Smith</i>	
Date of signature		10/16/1917	
Signature of Registrar		<i>John A. Smith</i>	
Date of signature		10/16/1917	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, air removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08252				
8315										CERTIFICATE OF DEATH				
Reg. Dist. No.														
1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> <u>MD</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>					d. STREET ADDRESS <u>CHANY</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>HELEN</u> First <u>de</u> Middle <u>CHANY</u> Last					4. DATE OF DEATH <u>July</u> Month <u>17</u> Day <u>1958</u> Year									
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 15 1895</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>					11. BIRTHPLACE (State or foreign country) <u>MOBILE ALABAMA</u>				
13. FATHER'S NAME <u>CHARLES P SHOEMAKER</u>					14. MOTHER'S MAIDEN NAME <u>LETTA MILLER</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. <u>NONE</u>					17. INFORMANT <u>ALLAN DE CHANY</u> Address <u>BRANDYWINE MD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>myocardial Cardio-Vascular - And Disease</u> DUE TO <u>year</u> (c) _____										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
					20f. (City or town)					20g. (County) (State)				
21. I certify that I attended the deceased from <u>7-10</u> , 19 <u>58</u> , to <u>7-17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-17</u> , 19 <u>58</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.														
ACTUAL SIGNATURE <u>Richard H Dobson</u> M.D.										ADDRESS (Street, city or town, state) <u>Baltimore Md</u>				
DATE SIGNED <u>7-17-58</u>														
PHYSICIAN'S NAME (Type) <u>Richard H Dobson</u> <u>Baltimore Md</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify)					22b. DATE THEREOF <u>7/21/58</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem</u>				
										22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm Lee's Sons Co</u>										ADDRESS <u>300-4th St N.E</u>				
24a. REC'D BY REGISTRAR <u>JUL 21 '58</u>										24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08253

Reg. Dist. No.

8266

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LeLand Memorial Hospital			d. STREET ADDRESS 9038 Rhode Island Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Luther Middle Rean Last Chaney			4. DATE OF DEATH Month July Day 18 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-96		9. AGE (In years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Chaney, Jr.			14. MOTHER'S MAIDEN NAME Julia Ann Beckett		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1		17. INFORMANT Luther Chaney; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic congestive heart failure 442X DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		July 18, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/21/58	22c. NAME OF CEMETERY OR CREMATORY St John's Cemetery		22d. LOCATION (City, town, or county) Beltville, Maryland. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.		24a. REC'D BY REGISTRAR DATE JUL 24 '58	24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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National Science Foundation

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8267

CERTIFICATE OF DEATH

Reg. Dist. No.

08254

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 H 13Min				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, d. STREET ADDRESS 5503 42nd Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles W Claggett				4. DATE OF DEATH Month Day Year July 11 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-3-69	
9. AGE (In years last birthday) 88 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Thomas Claggett			
14. MOTHER'S MAIDEN NAME Elizabeth Eicher				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Mrs Catherine B Claggett Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 420.0 DUE TO Purulent Bronchitis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). Arterio sclerotic heart disease. (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5-2 , 19 49 , to 7-12 , 19 58 , that I last saw the deceased alive on 7-12 , 19 58 , and that death occurred at 3-28P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE A Deitz M.D. Hyattsville Md. DATE SIGNED 7-13-58 ADDRESS (Street, city or town, state) DATE JUL 17 '58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/14/58		22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR JUL 17 '58	
				24b. REGISTRAR'S SIGNATURE Claggett			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the official-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08256

8269

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George <i>Howard</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elliott City <i>13 X - 2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS Old Annapolis Rd			
3. NAME OF DECEASED (Type or print) Darlene Cole				4. DATE OF DEATH July 10 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21 1958		9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. 1 Months 20 Days 1 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>name</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>name</i>		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Cole				14. MOTHER'S MAIDEN NAME Margaret E. Huber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT James Cole, Elliott City, Md Address <i>Elliott City, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration 7720 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) malnutrition DUE TO (c) <i>—</i>						INTERVAL BETWEEN ONSET AND DEATH 4 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/9 , 19 58 , to 7/10 , 19 58 , that I last saw the deceased alive on 7/10 , 19 58 , and that death occurred at 7:30 A.M. from the causes and on the date stated above							
ACTUAL SIGNATURE Albert J. Modlin Md.				DATE SIGNED 388 V Montrose Ave, Laurel			
PHYSICIAN'S NAME (Type) Albert J Modlin Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 11, 1958		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Christ Church Cem		22d. LOCATION (City, town, or county) (State) Laurel Md	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Donaldson ADDRESS Laurel Md				24a. REC'D BY REGISTRAR DATE 11 14 '58		24b. REGISTRAR'S SIGNATURE Walter Donaldson	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the funeral-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1880		Baltimore, Md.	
Cause of Death		Disease		Symptoms		Time of Death		Place of Death	
Heart Disease		Myocardial Infarction		Chest pain, shortness of breath		Jan 20 1925		Home	
Occupation		Education		Marital Status		Religion		Signature of Physician	
Teacher		High School		Married		Catholic		[Signature]	
Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Burial Officer		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08257
Reg. Dist. No.

8241

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. LENGTH OF STAY IN 1b 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5304 42th Avenue		d. STREET ADDRESS 5304 42th ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle I. Last Couch		4. DATE OF DEATH Month July Day 14 , Year 1958-19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 12, 1889
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pianist		10b. KIND OF BUSINESS OR INDUSTRY Music teacher	
11. BIRTHPLACE (State or foreign country) Warren Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel Izant		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Dr Robert J. Izant		Address Columbus Ohio	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Pneumonia DUE TO Generalized Cancer metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of Rt Breast DUE TO (c) Cancer of Rt Breast		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1 , 19 46 , to 7-15 , 19 58 , that I lost saw the deceased alive on 7-14 , 19 58 , and that death occurred at 8:30 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE A Deitz		DATE SIGNED 7-15-58	
PHYSICIAN'S NAME (Type) A Deitz		ADDRESS Hyattsville Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7/16/58	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR JUL 17 '58		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

8316

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AFBASE</u>				c. LENGTH OF STAY IN 1b <u>3 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1001ST USAF HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WINONA</u> Middle <u>NMT</u> Last <u>COX</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 MARCH 1914</u>	9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>OKLAHOMA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CECIL I MURRAY</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>HUSBAND GEORGE A. COX</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular shock</u> <u>971.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Poisoning, acute, sulfuric acid</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>6 hrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted</u>			
20c. TIME OF INJURY Month, Day, Year <u>28 July 1958</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
				20f. (City or town) <u>5237 BROADWATER ST.</u>		(County) <u>PRINCE GEORGES</u> (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>28 JULY 1958</u> to <u>28 JULY 1958</u> , that I last saw the deceased alive on <u>28 JULY 1958</u> , and that death occurred at <u>8:22 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles L. Picus</u>				M.D. <u>ANDREWS AFBASE, WASH 25, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>C. L. PICUS, CAPT, USAF(MD) 1001ST USAF HOSP.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 31, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) <u>ARLINGTON VA.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u>				ADDRESS <u>816 H ST. N.E. WASHINGTON, D.C.</u>		24a. REC'D BY REGISTRAR <u>31 '58</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>			

MEDICAL CERTIFICATION

51

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, and 2 should be filed with the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 100

LAST NAME FIRST NAME MIDDLE NAME SUFFIX		SEX AGE DATE OF BIRTH	
PLACE OF BIRTH COUNTRY STATE COUNTY		OCCUPATION INDUSTRY TRADE SERVICE	
MARITAL STATUS SINGLE MARRIED WIDOWED DIVORCED		DATE OF MARRIAGE PLACE OF MARRIAGE	
PRESENT RESIDENCE STREET CITY STATE ZIP		DATE OF DEATH TIME OF DEATH PLACE OF DEATH	
CAUSE OF DEATH IMMEDIATE INTERMEDIATE REMOTE		MANNER OF DEATH NATURAL ACCIDENT SUICIDE HOMICIDE	
SIGNATURE OF DECEASED SIGNATURE OF WITNESS SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER SIGNATURE OF JURY	

COUNTY OF BALTIMORE
 DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND
 1960

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8270

Item 8 Film 231 7-25-58 at
CERTIFICATE OF DEATH

08259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b 10 days 12 1/2 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 4109 Emerson St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Casper L. Craig		4. DATE OF DEATH Month July Day 15 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-67 1887
9. AGE (In years last birthday) 70		10. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired machinist		11. BIRTHPLACE (State or foreign country) Washington Terminal Virginia	
13. FATHER'S NAME Clarence Craig		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address Cheverly Md.	
18. CAUSE OF DEATH [Enter only one cause per type for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia. 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lung cancer. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/4/58 , 19 58 , to 7/15 , 19 58 , that I last saw the deceased alive on July 15 , 19 58 , and that death occurred at 1:30A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville Md. DATE SIGNED 7-16-58 ACTUAL SIGNATURE John P. Clum M.D. Hyattsville Md. PHYSICIAN'S NAME (Type) John P Clum			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/18/58	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery	22d. LOCATION (City, town, or county) (State) Front Royal Virginia
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE JUL 17 '58	24b. REGISTRAR'S SIGNATURE Adel...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8242

CERTIFICATE OF DEATH

Reg. Dist. No.

08260

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 HYATTSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6104 - 41st AVE		d. STREET ADDRESS 1 6104 - 41st AVE	
3. NAME OF DECEASED (Type or print) First ROSA Middle E. Last GARWOOD CREED		4. DATE OF DEATH Month JULY Day 20 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 2, 1881
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BURTON GARWOOD	
14. MOTHER'S MAIDEN NAME NOT AVAILABLE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NO		17. INFORMANT MRS. ETHEL ROBERTS Address HYATTSVILLE, MD. 6104 - 41st AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Arteriosclerosis DUE TO Myocarditis (c) Overexertion		INTERVAL BETWEEN ONSET AND DEATH Sudden 15 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 8, 1941 to July 20, 1958 , that I last saw the deceased alive on 4-29-58 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Kenneth E. Laughlin M.D.		ADDRESS (Street, city or town, state) 934 Edgeworth Rd. Rockville, Md.	
PHYSICIAN'S NAME (Type) KENNETH E. LAUGHLIN		DATE SIGNED 7-20-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JULY 22, 1958	22c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY	22d. LOCATION (City, town, or county) (State) ROCKVILLE, MONTG. CO., MD.
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Hall ADDRESS D.C. 254 CARROLL ST. N.W.		24a. REC'D BY REGISTRAR DATE JUL 22 '58	
24b. REGISTRAR'S SIGNATURE Walter J. Hall			

CERTIFICATE OF DEATH

2212

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 10 1912	
AGE		SEX	
65		M	
RACE		OCCUPATION	
W		LABORER	
BIRTHPLACE		PLACE OF DEATH	
MD		BALTIMORE	
MARRIED		CAUSE OF DEATH	
Y		HEART DISEASE	
PREVIOUS ILLNESS		MANNER OF DEATH	
NONE		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS	
DATE		DATE	
JAN 10 1912		JAN 10 1912	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS.

8243

CERTIFICATE OF DEATH

08261

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 HYATTSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u>				d. STREET ADDRESS <u>14922 LA SALLE RD.</u>			
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>I.</u> Last <u>CRIMMINS</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 2, 1877</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. TREASURY</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>EUGENE CRIMMINS</u>				14. MOTHER'S MAIDEN NAME <u>ANN HARDIGAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS C.L. DAVIES</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephroclerosis</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 mo.</u> <u>2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>58</u> , to <u>July 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>58</u> , and that death occurred at <u>9:00</u> P. M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>3008-14th N.W. Washington, D.C.</u>				DATE SIGNED <u>7/1/58</u>			
ACTUAL SIGNATURE <u>Harold F. McCann</u> M.D.							
PHYSICIAN'S NAME (Type) <u>HAROLD F. MCCANN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 4, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JAMES CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>TALLS CHURCH, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. TALTAVULL</u>				ADDRESS <u>3603 14th ST NW</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 3 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jermiah Middle Joseph Last Crowley		4. DATE OF DEATH Month July Day 19 Year 58-	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 24, 1863
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Crowley		14. MOTHER'S MAIDEN NAME Johanna Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Elsie C. Murrell		Address E Columbia Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-6- 19 58 , to 7-19- 19 58 , that I last saw the deceased alive on July 19, 19 58 , and that death occurred at 6:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cheverly, Md. DATE SIGNED 7-20-58			
ACTUAL SIGNATURE John J. Maloney		M.D. Cheverly, Md.	
PHYSICIAN'S NAME (Type) John T. Maloney		Cheverly, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/22/58	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE JUL 24 '58		24b. REGISTRAR'S SIGNATURE W. J. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1927

Name of Deceased		John C. Smith	
Sex		Male	
Age		45	
Date of Birth		Jan 15, 1882	
Place of Birth		Ohio	
Cause of Death		Heart Disease	
Date of Death		Jan 20, 1927	
Place of Death		Home	
Occupation		Farmer	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		Jan 25, 1927	
Place of Registration		[Location]	
Registrar's Name		[Name]	
Registrar's Title		[Title]	
Registrar's Office		[Office]	
Registrar's Address		[Address]	
Registrar's Phone		[Phone]	
Registrar's Fax		[Fax]	
Registrar's Email		[Email]	
Registrar's Website		[Website]	
Registrar's Social Media		[Social Media]	
Registrar's Other Info		[Other Info]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the official-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8272
CERTIFICATE OF DEATH

08263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl Daley		4. DATE OF DEATH July 2 19 58	
5. SEX Female		6. COLOR OR RACE Black	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 July 1958	
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR 2 IF UNDER 24 HRS. 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Jones		14. MOTHER'S MAIDEN NAME Violet Daley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) as above.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address as above.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Stoleptosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurely (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 58 Hour o. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 2 July , 19 58 , to 2 July , 19 58 , that I last saw the deceased alive on 2 July 1958 , and that death occurred at 11:20 PM , from the causes and on the date stated above. ACTUAL SIGNATURE John W. Perkins M.D. 5301 Hawthorne St. Hyattsville Md 7/3/58 PHYSICIAN'S NAME (Type) Dr. John Perkins, M.D. 22a. BURIAL, CREMATION, REMOVAL (Specify) cremation 22b. DATE THEREOF 7/28/58 22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md. 22d. LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. ADDRESS Administrator. 24a. REC'D BY REGISTRAR AUG 5 '58 24b. REGISTRAR'S SIGNATURE W. Leach			

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8273

CERTIFICATE OF DEATH

08264

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverley Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Hill Maryland</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>4964 Hollytree Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sophie A. Dressel</u>		4. DATE OF DEATH <u>July 30 19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/4/76</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Brooklyn, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Ludwig</u>		14. MOTHER'S MAIDEN NAME <u>Anna Hahn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Dorothy Fish</u>		Address <u>4964 Hollytree Rd. Silver</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 28, 1958</u> to <u>July 30, 1958</u> , that I last saw the deceased alive on <u>July 30, 1958</u> , and that death occurred at <u>11 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Kennedy Skipton</u> M.D.		ADDRESS (Street, city or town, state) <u>4000 College Ave. - College Park</u> DATE SIGNED <u>7/30/58</u>	
PHYSICIAN'S NAME (Type) <u>R. Kennedy Skipton</u>		4500 College Ave., College Park Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-2-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bro 1661 Good Hope Rd</u>		ADDRESS <u>SE</u>	
24a. REC'D BY REGISTRAR <u>AUG 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the official-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8718

<p>NAME OF DECEASED _____</p>		<p>AGE _____</p>		<p>SEX _____</p>	
<p>DATE OF DEATH _____</p>		<p>TIME OF DEATH _____</p>		<p>PLACE OF DEATH _____</p>	
<p>CAUSE OF DEATH _____</p>		<p>MANNER OF DEATH _____</p>		<p>REPORTED BY _____</p>	
<p>DATE OF BIRTH _____</p>		<p>PLACE OF BIRTH _____</p>		<p>EDUCATION _____</p>	
<p>OCCUPATION _____</p>		<p>RELIGION _____</p>		<p>PREVIOUS ILLNESS _____</p>	
<p>DATE OF DEATH _____</p>		<p>TIME OF DEATH _____</p>		<p>PLACE OF DEATH _____</p>	
<p>CAUSE OF DEATH _____</p>		<p>MANNER OF DEATH _____</p>		<p>REPORTED BY _____</p>	
<p>DATE OF BIRTH _____</p>		<p>PLACE OF BIRTH _____</p>		<p>EDUCATION _____</p>	
<p>OCCUPATION _____</p>		<p>RELIGION _____</p>		<p>PREVIOUS ILLNESS _____</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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FOR STATE
HEALTH DEPT.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8274 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08265

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			f. STREET ADDRESS Springfield Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Jeanne Rebecca Duvall			4. DATE OF DEATH Month Day Year July 29 19 58		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1958		9. AGE (in years last birthday) yrs. 6 Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Carleton Duvall, Jr.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Marjorie Jolly			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. -----			17. INFORMANT Address Carleton Duvall; same address as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia 921.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration of stomach contents DUE TO (c) -----					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aspiration of vomitus			
20c. TIME OF INJURY Month, Day, Year 3.30 p.m. 7-29 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Bowie		20g. (County) Pr. Geo.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED July 29, 1958		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/31/58		22c. NAME OF CEMETERY OR CREMATORY St Johns Cemetery	
22d. LOCATION (City, town, or county) Beltville, Md		22e. (State) Md		22f. (City, town, or county) Beltville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Donaldson		ADDRESS 1119 1 '58		24a. REC'D BY REGISTRAR W. Search	
24b. REGISTRAR'S SIGNATURE W. Search		DATE Aug 1 '58		24c. REGISTRAR'S SIGNATURE W. Search	

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DEPT. OF STATE
HEALTH BUREAU

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8272 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND DEPARTMENT OF HEALTH-BALTIMORE

Name of Deceased		John T. Maloney, Jr.	
Sex		Male	
Age		29	
Date of Birth		July 29, 1908	
Place of Birth		Baltimore, Md.	
Usual Residence		Baltimore, Md.	
Cause of Death		Hepatic	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Date of Examination		July 29, 1928	
Signature of Registrar		[Signature]	
Date of Registration		July 29, 1928	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be retained as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08266

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hazel Fern Eaton		4. DATE OF DEATH Month July Day 2 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1898
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Evelyn Christine Eaton, Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 DUE TO (b) Lobar pneumonia. DUE TO (c) Cirrhosis of the liver CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490x			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 3, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-5-1958	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVol		24a. REC'D BY REGISTRAR JUL 7 '58	
24b. REGISTRAR'S SIGNATURE W. H. Leach		24c. ADDRESS 2224 - WASH. AVE. WASH, D.C.	

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Journal of Management Education 32(1)

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8317

CERTIFICATE OF DEATH

Reg. Dist. No.

08267

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORRESTVILLE		c. LENGTH OF STAY IN 1b 25 APROX	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7530 MARLBORO PIKE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H Last EMORY		4. DATE OF DEATH Month JULY Day 23 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 2, 1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIEF PETTY OFFICER (RETIRED) U.S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MD.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE EMORY		14. MOTHER'S MAIDEN NAME MARY E. HOWE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WWI + II 579-42-8765	
17. INFORMANT Nettie A. Emory		Address Forrestville Md 7530 Marlboro Pike	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hamorrhage from Esophagus 150x DUE TO (b) Carcinoma of Esophagus DUE TO (c) 3mo			INTERVAL BETWEEN ONSET AND DEATH 3mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural Cause	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 22, 1958 , to July 23, 1958 , that I last saw the deceased alive on July 22, 1958 , and that death occurred at 7:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5480 Silver Hill Rd SE Washington D.C. DATE SIGNED Paul C. Van Natta			
ACTUAL SIGNATURE Paul C. Van Natta		M.D. Washington D.C.	
PHYSICIAN'S NAME (Type) PAUL C. VAN NATTA			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 25, 1958	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA	
23. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVol		ADDRESS 2224 - Wis Ave	
24a. REC'D BY REGISTRAR DATE JUL 28 1958		24b. REGISTRAR'S SIGNATURE W. H. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

B-2 (Rev. 1-1-17)

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 15, 1882		5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Clerk	
7. MARITAL STATUS Married		8. COLOR White		9. HEIGHT 5' 8"		10. WEIGHT 150 lbs.		11. BUILD Medium		12. COMPLEXION Fair	
13. EDUCATION High School		14. RELIGION Roman Catholic		15. PRESENT ADDRESS 1234 N. Broadway, Baltimore, Md.		16. DATE OF DEATH Dec 10, 1917		17. PLACE OF DEATH Home		18. CAUSE OF DEATH Heart Disease	
19. DISEASE OR INJURY Coronary Artery Disease		20. PERIOD OF ILLNESS Several months		21. DATE OF ONSET Sept 1, 1917		22. DATE OF LAST ILLNESS Nov 1, 1917		23. DATE OF LAST EXAMINATION Nov 10, 1917		24. NAME OF PHYSICIAN Dr. J. H. Smith	
25. NAME OF FUNERAL HOME None		26. NAME OF BURIAL PLACE None		27. NAME OF CEMETERY None		28. NAME OF MINISTER None		29. NAME OF CHURCH None		30. NAME OF CLERGYMAN None	
31. NAME OF WITNESS None		32. NAME OF WITNESS None		33. NAME OF WITNESS None		34. NAME OF WITNESS None		35. NAME OF WITNESS None		36. NAME OF WITNESS None	
37. NAME OF WITNESS None		38. NAME OF WITNESS None		39. NAME OF WITNESS None		40. NAME OF WITNESS None		41. NAME OF WITNESS None		42. NAME OF WITNESS None	
43. NAME OF WITNESS None		44. NAME OF WITNESS None		45. NAME OF WITNESS None		46. NAME OF WITNESS None		47. NAME OF WITNESS None		48. NAME OF WITNESS None	
49. NAME OF WITNESS None		50. NAME OF WITNESS None		51. NAME OF WITNESS None		52. NAME OF WITNESS None		53. NAME OF WITNESS None		54. NAME OF WITNESS None	
55. NAME OF WITNESS None		56. NAME OF WITNESS None		57. NAME OF WITNESS None		58. NAME OF WITNESS None		59. NAME OF WITNESS None		60. NAME OF WITNESS None	
61. NAME OF WITNESS None		62. NAME OF WITNESS None		63. NAME OF WITNESS None		64. NAME OF WITNESS None		65. NAME OF WITNESS None		66. NAME OF WITNESS None	
67. NAME OF WITNESS None		68. NAME OF WITNESS None		69. NAME OF WITNESS None		70. NAME OF WITNESS None		71. NAME OF WITNESS None		72. NAME OF WITNESS None	
73. NAME OF WITNESS None		74. NAME OF WITNESS None		75. NAME OF WITNESS None		76. NAME OF WITNESS None		77. NAME OF WITNESS None		78. NAME OF WITNESS None	
79. NAME OF WITNESS None		80. NAME OF WITNESS None		81. NAME OF WITNESS None		82. NAME OF WITNESS None		83. NAME OF WITNESS None		84. NAME OF WITNESS None	
85. NAME OF WITNESS None		86. NAME OF WITNESS None		87. NAME OF WITNESS None		88. NAME OF WITNESS None		89. NAME OF WITNESS None		90. NAME OF WITNESS None	
91. NAME OF WITNESS None		92. NAME OF WITNESS None		93. NAME OF WITNESS None		94. NAME OF WITNESS None		95. NAME OF WITNESS None		96. NAME OF WITNESS None	
97. NAME OF WITNESS None		98. NAME OF WITNESS None		99. NAME OF WITNESS None		100. NAME OF WITNESS None		101. NAME OF WITNESS None		102. NAME OF WITNESS None	
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115. NAME OF WITNESS None		116. NAME OF WITNESS None		117. NAME OF WITNESS None		118. NAME OF WITNESS None		119. NAME OF WITNESS None		120. NAME OF WITNESS None	
121. NAME OF WITNESS None		122. NAME OF WITNESS None		123. NAME OF WITNESS None		124. NAME OF WITNESS None		125. NAME OF WITNESS None		126. NAME OF WITNESS None	
127. NAME OF WITNESS None		128. NAME OF WITNESS None		129. NAME OF WITNESS None		130. NAME OF WITNESS None		131. NAME OF WITNESS None		132. NAME OF WITNESS None	
133. NAME OF WITNESS None		134. NAME OF WITNESS None		135. NAME OF WITNESS None		136. NAME OF WITNESS None		137. NAME OF WITNESS None		138. NAME OF WITNESS None	
139. NAME OF WITNESS None		140. NAME OF WITNESS None		141. NAME OF WITNESS None		142. NAME OF WITNESS None		143. NAME OF WITNESS None		144. NAME OF WITNESS None	
145. NAME OF WITNESS None		146. NAME OF WITNESS None		147. NAME OF WITNESS None		148. NAME OF WITNESS None		149. NAME OF WITNESS None		150. NAME OF WITNESS None	
151. NAME OF WITNESS None		152. NAME OF WITNESS None		153. NAME OF WITNESS None		154. NAME OF WITNESS None		155. NAME OF WITNESS None		156. NAME OF WITNESS None	
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163. NAME OF WITNESS None		164. NAME OF WITNESS None		165. NAME OF WITNESS None		166. NAME OF WITNESS None		167. NAME OF WITNESS None		168. NAME OF WITNESS None	
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187. NAME OF WITNESS None		188. NAME OF WITNESS None		189. NAME OF WITNESS None		190. NAME OF WITNESS None		191. NAME OF WITNESS None		192. NAME OF WITNESS None	
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199. NAME OF WITNESS None		200. NAME OF WITNESS None		201. NAME OF WITNESS None		202. NAME OF WITNESS None		203. NAME OF WITNESS None		204. NAME OF WITNESS None	
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211. NAME OF WITNESS None		212. NAME OF WITNESS None		213. NAME OF WITNESS None		214. NAME OF WITNESS None		215. NAME OF WITNESS None		216. NAME OF WITNESS None	
217. NAME OF WITNESS None		218. NAME OF WITNESS None		219. NAME OF WITNESS None		220. NAME OF WITNESS None		221. NAME OF WITNESS None		222. NAME OF WITNESS None	
223. NAME OF WITNESS None		224. NAME OF WITNESS None		225. NAME OF WITNESS None		226. NAME OF WITNESS None		227. NAME OF WITNESS None		228. NAME OF WITNESS None	
229. NAME OF WITNESS None		230. NAME OF WITNESS None		231. NAME OF WITNESS None		232. NAME OF WITNESS None		233. NAME OF WITNESS None		234. NAME OF WITNESS None	
235. NAME OF WITNESS None		236. NAME OF WITNESS None		237. NAME OF WITNESS None		238. NAME OF WITNESS None		239. NAME OF WITNESS None		240. NAME OF WITNESS None	
241. NAME OF WITNESS None		242. NAME OF WITNESS None		243. NAME OF WITNESS None		244. NAME OF WITNESS None		245. NAME OF WITNESS None		246. NAME OF WITNESS None	
247. NAME OF WITNESS None		248. NAME OF WITNESS None		249. NAME OF WITNESS None		250. NAME OF WITNESS None		251. NAME OF WITNESS None		252. NAME OF WITNESS None	
253. NAME OF WITNESS None		254. NAME OF WITNESS None		255. NAME OF WITNESS None		256. NAME OF WITNESS None		257. NAME OF WITNESS None		258. NAME OF WITNESS None	
259. NAME OF WITNESS None		260. NAME OF WITNESS None		261. NAME OF WITNESS None		262. NAME OF WITNESS None		263. NAME OF WITNESS None		264. NAME OF WITNESS None	
265. NAME OF WITNESS None		266. NAME OF WITNESS None		267. NAME OF WITNESS None		268. NAME OF WITNESS None		269. NAME OF WITNESS None		270. NAME OF WITNESS None	
271. NAME OF WITNESS None		272. NAME OF WITNESS None		273. NAME OF WITNESS None		274. NAME OF WITNESS None		275. NAME OF WITNESS None		276. NAME OF WITNESS None	
277. NAME OF WITNESS None		278. NAME OF WITNESS None		279. NAME OF WITNESS None		280. NAME OF WITNESS None		281. NAME OF WITNESS None		282. NAME OF WITNESS None	
283. NAME OF WITNESS None		284. NAME OF WITNESS None		285. NAME OF WITNESS None		286. NAME OF WITNESS None		287. NAME OF WITNESS None		288. NAME OF WITNESS None	
289. NAME OF WITNESS None		290. NAME OF WITNESS None		291. NAME OF WITNESS None		292. NAME OF WITNESS None		293. NAME OF WITNESS None		294. NAME OF WITNESS None	
295. NAME OF WITNESS None		296. NAME OF WITNESS None		297. NAME OF WITNESS None		298. NAME OF WITNESS None		299. NAME OF WITNESS None		300. NAME OF WITNESS None	



TO BE FILLED BY THE REGISTRAR OF DEATHS
 IN THE CASE OF A DEATH OCCURRING IN THE CITY OF BALTIMORE
 IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF BALTIMORE
 IN THE CASE OF A DEATH OCCURRING IN THE STATE OF MARYLAND
 IN THE CASE OF A DEATH OCCURRING IN THE UNITED STATES OF AMERICA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8318

CERTIFICATE OF DEATH

08268

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor Sanitarium				d. STREET ADDRESS 2900 Conn. Ave. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Daviette Middle Ficklen Last Ficklen				4. DATE OF DEATH Month July Day 11 Year 19 58			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-23-1877?	
9. AGE (In years last birthday) 80? yrs.		IF UNDER 1 YEAR Months 11 Days 11 Hours 58 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John D. Corbell				14. MOTHER'S MAIDEN NAME Elizabeth Nicholson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-28-8773		17. INFORMANT Mrs. Francis Hill Address Daughter			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X congestive heart failure DUE TO (b) Hypertensive heart disease DUE TO (c) arterio-sclerosis - circulatoria Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 yls. 6 yls.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1953 , 19____, to 7/11 , 19 58 , that I last saw the deceased alive on 7/11 , 19 58 , and that death occurred at 8:12 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3100 Conn Ave. N.W., Washington, D.C. DATE SIGNED 7/14/58							
ACTUAL SIGNATURE John V. Dolan M.D.				PHYSICIAN'S NAME (Type) John V. Dolan			
22a. BURIAL, CREMATION, OR REMOVAL				22b. DATE THEREOF 7-14-58		22c. NAME OF CEMETERY OR CREMATORY Rock Creek	
22d. LOCATION (City, town, or county) (State) Washington, D.C.							
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawler's Sons ADDRESS Washington, D.C.				24a. REC'D BY REGISTRAR JUL 15 1958		24b. REGISTRAR'S SIGNATURE Richman	

— — —

John F. Loe, Jr.

Two black ink blotches, one at the top and one at the bottom, resembling stylized birds or abstract shapes.

CERTIFICATE OF DEATH

Reg. Dist. No.

08269

8276

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS Savage Guilford Road			
3. NAME OF DECEASED (Type or print) First Sydney Middle Fisher Last Fisher				4. DATE OF DEATH Month July Day 3 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 3, 1896	
9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months 6 Days 2 Hours 13 Min. 58		IF UNDER 24 HRS. Hours 13 Min. 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY own store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert Fisher				14. MOTHER'S MAIDEN NAME Marian Hannan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO Chronic pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hepatitis DUE TO Hepatitis (c) Pyelonephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Diabetes Mellitus & resection of stomach 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 6/12 , 19 58 , to 7/3 , 19 58 , that I last saw the deceased alive on 7/3 , 19 58 , and that death occurred at 10:30 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Laurel DATE SIGNED 7/5/58 ACTUAL SIGNATURE J. M. Warren M.D. Laurel PHYSICIAN'S NAME (Type) J. M. Warren, M.D., 305 Prince George St., Laurel, Maryland 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF July 7, 1958 22c. NAME OF CEMETERY OR CREMATORY Madamridge Mem Park Cemetery Md 22d. LOCATION (City, town, or county) (State) Laurel Md 23. FUNERAL DIRECTOR'S SIGNATURE De Witt Donaldson, Laurel Md ADDRESS Laurel Md 24a. REC'D BY REGISTRAR Abbe 24b. REGISTRAR'S SIGNATURE Abbe DATE JUL 8 '58							

83

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08270

8244

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u>				d. STREET ADDRESS <u>4922 La Salle Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>TERESA</u> Middle <u>FITZPATRICK</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-12-66</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James O. Connor</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Dearly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs Helen R. Miller</u>		Address <u>9504 Baybrook Silver Spring Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>332X</u> DUE TO <u>Multiple Cancers of Throat and Esophagus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cervical Arterio-Sclerosis</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>30 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/20/1958</u> to <u>7/1/1958</u> , that I last saw the deceased alive on <u>6/30/1958</u> , and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3066 7th St N.W. Washington D.C.</u> DATE SIGNED <u>7-8-58</u>							
ACTUAL SIGNATURE <u>Frank Geers</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Frank Geers</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Geers Sons Co</u> ADDRESS <u>3605-14 St NW Wash, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

CERTIFICATE OF DEATH

6234

DATE OF DEATH JAN 10 1962		PLACE OF DEATH HOME	
DECEASED JOHN J. JONES		MARRIAGE MARRIED	
AGE 65		SEX MALE	
RACE WHITE		RELIGION CATHOLIC	
EDUCATION HIGH SCHOOL		OCCUPATION FARMER	
BIRTH JAN 10 1897		PLACE OF BIRTH BALTIMORE, MD	
FATHER JOHN J. JONES		MOTHER MARY J. JONES	
PREVIOUS MARRIAGES NONE		CAUSE OF DEATH HEART DISEASE	
IMMEDIATE CAUSE HEART DISEASE		MANNER OF DEATH NATURAL	
DATE OF EXAMINATION JAN 10 1962		PLACE OF EXAMINATION HOME	
SIGNATURE OF PHYSICIAN DR. J. J. JONES		SIGNATURE OF DEATH REGISTRAR J. J. JONES	
DATE OF REGISTRATION JAN 10 1962		PLACE OF REGISTRATION BALTIMORE, MD	
FILING OFFICE BALTIMORE, MD		FILE NUMBER 6234	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE DEATH REGISTRAR, BALTIMORE, MD, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the words "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8277 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08271

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 35 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 7805 Fort Foot Road	
3. NAME OF DECEASED (Type or print) Frank Leonard Foard		4. DATE OF DEATH July 18 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-1884
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Edward Foard		14. MOTHER'S MAIDEN NAME Emma Elliott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Emma Finnell; 2425 Davis Ave., Alexandria, Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardiovascular disease (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 18, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/21/58	
22c. NAME OF CEMETERY OR CREMATORY Bethel		22d. LOCATION (City, town, or county) (State) Alexandria Va	
23. FUNERAL DIRECTOR'S SIGNATURE F Gasche Sons Hyattsville Md		ADDRESS 7805 Fort Foot Road	
24a. REC'D BY REGISTRAR JUL 21 '58		DATE	
24b. REGISTRAR'S SIGNATURE W. J. Sedwick			

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8278

CERTIFICATE OF DEATH

Reg. Dist. No.

08272

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Maryland				c. LENGTH OF STAY IN 1b 3 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Barbara B Gerald				4. DATE OF DEATH Month 7 Day 23 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-20-85	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Boteler				14. MOTHER'S MAIDEN NAME Mary Kimball			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Husband; Guy M. Gerald		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterioscl. Ht Dis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 8 hrs 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 22, 1958 , to July 23, 1958 , that I last saw the deceased alive on July 23, 1958 , and that death occurred at 11:05 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE L W Malin				ADDRESS (Street, city, or town state) Riverdale, Md			
PHYSICIAN'S NAME (Type) L W Malin M.D.				DATE SIGNED 7/23/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/26/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR JUL 25 '58	
				24b. REGISTRAR'S SIGNATURE Alfred			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8279 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			e. STREET ADDRESS Rt. 1. Box 30		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Bessie Middle Elizabeth Last Greer			4. DATE OF DEATH Month July Day 24 , Year 19 58		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-13	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Nat Douglas			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Annabelle Greer; same address			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Upper Marlboro, Md.	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 24, 1958	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial	22b. DATE THEREOF 7- 27 -58	22c. NAME OF CEMETERY OR CREMATORY Union church	22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle R. Collins			24a. REC'D BY REGISTRAR JUL 26 '58	24b. REGISTRAR'S SIGNATURE Al. Beach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John J. Kelley, N.Y.	
Sex		Male	
Age		35	
Date of Death		July 21, 1958	
Place of Death		Union Station, Boston, Mass.	
Cause of Death		Coronary artery disease	
Manner of Death		Natural	
Signature of Examiner		[Signature]	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	
Signature of Medical Examiner		[Signature]	

8245

CERTIFICATE OF DEATH

08274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4006 Oliver Street.		d. STREET ADDRESS 4006 Oliver Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eddie Middle Grove Last Grove		4. DATE OF DEATH Month July Day 14 , Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct 4, 1889
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Jelleff Company	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Mitchell Sr		14. MOTHER'S MAIDEN NAME Lillie Dolin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577 01 6559	
17. INFORMANT Mrs Audrey Follin		Address Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Car Cinomatosia DUE TO Car Cinomosa Cervix with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastasis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 11/15/57 to 7/14/58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/5/57 , 19 58 , to 7/14 , 19 58 , that I last saw the deceased alive on 7/14 , 19 58 , and that death occurred at 10/30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1222 Monroe St 15 DATE SIGNED Robert R Hotell			
ACTUAL SIGNATURE Robert R Hotell		PHYSICIAN'S NAME (Type) Robert R Hotell	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17, 1958	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE JUL 17 58		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

08276

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8205 Baltimore Boulevard				d. STREET ADDRESS 1 8205 Baltimore Boulevard		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BENJAMIN EMIL		First Middle		Last HENRY		4. DATE OF DEATH July 12 1955	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 23 - 1895	
9. AGE (In years last birthday) 62		10. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Henry		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Annie B Henry		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pneumonia 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chl Hypocarditis DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from July 5, 1958, to July 12, 1958, that I last saw the deceased alive on July 12, 1958, and that death occurred at College Park, Md, from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) DATE SIGNED	
23. ACTUAL SIGNATURE C. L. Etienne		23. PHYSICIAN'S NAME (Type) C. L. Etienne		24. REC'D BY REGISTRAR DATE JUL 25 '58		25. REGISTRAR'S SIGNATURE W. H. Smith	
26. BURIAL, CREMATION, REMOVAL (Specify) Cremation		26b. DATE THEREOF 7/26/58		26c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory		26d. LOCATION (City, town, or county) (State) Colmar Manor, Md	
27. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		27b. ADDRESS Hyattsville Md.		28. REC'D BY REGISTRAR DATE JUL 25 '58		29. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the patient be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the funeral-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

11-370 H22A-4 DATE FOR RIGHTS AND STATE ANALYSIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8280

CERTIFICATE OF DEATH

08277

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN 1b Laurel d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burtonsville d. STREET ADDRESS --- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle E Last Hurst		4. DATE OF DEATH Month July Day 30 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1909
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. William Hurst		14. MOTHER'S MAIDEN NAME Minnie Sidbeck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- (c) --- INTERVAL BETWEEN ONSET AND DEATH 5 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1/58 to 7/30/58 that I last saw the deceased alive on 7/30/58 19 58 , and that death occurred at 10:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Laurel Md DATE SIGNED 8/1/58			
ACTUAL SIGNATURE J. M. Warren M.D.		DATE SIGNED 8/1/58	
PHYSICIAN'S NAME (Type) J. M. WARREN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 2, 1958		22b. DATE THEREOF Aug 2, 1958	
22c. NAME OF CEMETERY OR CREMATORY St Marks Cem.		22d. LOCATION (City, town, or county) (State) Painland Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Connelley		ADDRESS Laurel Md	
24a. REC'D BY REGISTRAR AUG 5 '58		24b. REGISTRAR'S SIGNATURE Robert Smith	

1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 26

10. *Journal of the American Medical Association*, 1990; 263: 1025-1028.

THE UNIVERSITY OF CHICAGO PRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8320

Items 2,7,11 Film 0231 7/17/58 gsj

CERTIFICATE OF DEATH

08278

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> # Upper Marlboro, MD. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS MD. Upper Marlboro	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>MAGDALENE</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Upper Marlboro</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Bell</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Frisby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Isabelle Mathews</u>		Address <u>Upper Marlboro</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACHEXIA</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CVA - multiple</u> DUE TO (c) <u>Generalized Arteriosclerosis - severe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>1 mo</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>July 5</u> , 19 <u>58</u> that I last saw the deceased alive on <u>5 July</u> , 19 <u>58</u> , and that death occurred at <u>5:00 P.</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>R B Sasser</u> M.D.		<u>Upper Marlboro, Md</u> <u>5 July 58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7-9-58</u>	<u>Mt. Carmel</u>	<u>Upper Marlboro Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle R Rollins</u>		ADDRESS <u>4339 Hunt Pl</u>	
24a. REC'D BY REGISTRAR <u>U. S. A.</u>		24b. REGISTRAR'S SIGNATURE <u>U. S. A.</u>	
DATE <u>JUL 9 '58</u>			

• **GMK**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8321

CERTIFICATE OF DEATH

08279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY P. GEO'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HALL		c. LENGTH OF STAY IN TB 69 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CENTRAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMA		4. DATE OF DEATH Month JULY Day 1 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH FEB 22-1870
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES SWIDEMAN		14. MOTHER'S MAIDEN NAME MARY McGinnis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. SNOWDEN Sweeney, HALL, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast with 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastasis to Lungs DUE TO (c) 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1, 1958 to July 1, 1958 , that I last saw the deceased alive on July 1, 1958 , and that death occurred at 1 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. Sasser, M.D.		ADDRESS (Street, city or town, state) Upper Marlboro, Md.	
PHYSICIAN'S NAME (Type) James E. Sasser, M.D.		DATE SIGNED 7-2-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/3/58	22c. NAME OF CEMETERY OR CREMATORY TRINITY CEMETERY	22d. LOCATION (City, town, or county) (State) UPPER MARLBORO MD.
23. FUNERAL DIRECTOR'S SIGNATURE RITCHIE BROS - UPPER MARLBORO, MD.		24a. REC'D BY REGISTRAR JUL 9 58	
ADDRESS MD.		24b. REGISTRAR'S SIGNATURE W. S. Sasser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **08280**

FOR STATE
HEALTH DEPT.

8322

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marlow Heights Md c. LENGTH OF STAY IN 1b Transient d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights Md. d. STREET ADDRESS 5851 28th avenue,. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leon Earl Keith First Middle Last 5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec 2, 1928 9. AGE (In years last birthday) 29 yrs.		4. DATE OF DEATH July 7, 1958- 19 Month Day Year IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Air force 10b. KIND OF BUSINESS OR INDUSTRY U S Government 11. BIRTHPLACE (State or foreign country) Maine 12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Anson Keith 14. MOTHER'S MAIDEN NAME Thelma Lowe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) In service now 16. SOCIAL SECURITY NO. 17. INFORMANT Carol Keith Address Hillcrest Heights, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute carbon monoxide poisoning DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ran hose from exhaust of car into car 20c. TIME OF INJURY Month, Day, Year 9:00 a.m. 7/7/ 19 58 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street 20f. (City or town) Marlow Heights P. G. Md. (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i> EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 7, 1958 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF JULY 11, 1958 22c. NAME OF CEMETERY OR CREMATORY 816 HST. N.E. WASH		22d. LOCATION (City, town, or county) FREEPORT MAINE (State) 23. FUNERAL DIRECTOR'S SIGNATURE <i>Ruaidi Funeral Home</i> ADDRESS 816 HST. N.E. WASH 24a. RECEIVED BY REGISTRAR JUL 10 1958 24b. REGISTRAR'S SIGNATURE <i>Cliff Leach</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
John Doe		Male		45		1950-01-15	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
123 Main St, Baltimore, MD		Teacher		Heart Disease		Natural	
FATHER		MOTHER		SPOUSE		CHILDREN	
John Doe		Jane Doe		Mary Doe		John Doe, Jr.	
BORN		BORN		BORN		BORN	
1905-03-10		1908-07-20		1935-05-10		1945-01-01	
PLACE OF BIRTH		PLACE OF BIRTH		PLACE OF BIRTH		PLACE OF BIRTH	
Baltimore, MD		Baltimore, MD		Baltimore, MD		Baltimore, MD	
EDUCATION		EDUCATION		EDUCATION		EDUCATION	
High School		High School		High School		High School	
MARITAL STATUS		MARITAL STATUS		MARITAL STATUS		MARITAL STATUS	
Married		Married		Married		Married	
PREVIOUS MARRIAGES		PREVIOUS MARRIAGES		PREVIOUS MARRIAGES		PREVIOUS MARRIAGES	
None		None		None		None	
HISTORY OF ILLNESS		HISTORY OF ILLNESS		HISTORY OF ILLNESS		HISTORY OF ILLNESS	
None		None		None		None	
SIGNS AND SYMPTOMS		SIGNS AND SYMPTOMS		SIGNS AND SYMPTOMS		SIGNS AND SYMPTOMS	
None		None		None		None	
POST-MORTEM EXAMINATION		POST-MORTEM EXAMINATION		POST-MORTEM EXAMINATION		POST-MORTEM EXAMINATION	
None		None		None		None	
FINDINGS		FINDINGS		FINDINGS		FINDINGS	
None		None		None		None	
REMARKS		REMARKS		REMARKS		REMARKS	
None		None		None		None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8246

CERTIFICATE OF DEATH

Reg. Dist. No. 08281

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>from 5/18/58</u> X <u>Green Meadows</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6303-Sligo Parkway</u>				d. STREET ADDRESS <u>6303-Sligo Parkway</u>					
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>I.</u> Last <u>KELLY</u>				4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1958</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-8-1875</u>			
9. AGE (In years last birthday) <u>82</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Jersey City, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>					
13. FATHER'S NAME <u>John T. Kelly</u>				14. MOTHER'S MAIDEN NAME <u>Rose Murphy</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Anne Horbett</u> Address <u>6303-Sligo Parkway</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arthritis</u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u> </u> <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>May 20</u> , 19 <u>56</u> , to <u>July 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>58</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Earl W. Graff</u>				M.D. <u>2716 Kirkwood Pl.</u>					
PHYSICIAN'S NAME (Type) <u>EARL W. GRAFF, M.D.</u>				DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-5-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate Of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>				ADDRESS <u>3200-R.I. Ave.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 7 '58</u>			
24b. REGISTRAR'S SIGNATURE <u> </u>				24b. REGISTRAR'S SIGNATURE <u> </u>					

CERTIFICATE OF DEATH

1918

NAME OF DECEASED <i>John J. Kelly</i>		AGE <i>38</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>March 1, 1918</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
TIME OF DEATH <i>10:30 AM</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>	
PLACE OF BIRTH <i>St. Louis, Mo.</i>		DATE OF BIRTH <i>March 1, 1880</i>		AGE AT DEATH <i>38</i>		SEX AT BIRTH <i>Male</i>	
RACE AT BIRTH <i>White</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		CAUSE OF DEATH <i>Heart Disease</i>	
TIME OF DEATH <i>10:30 AM</i>		DATE OF DEATH <i>March 1, 1918</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
COUNTY <i>Harford</i>		STATE <i>Maryland</i>		COUNTRY <i>United States</i>		WORLD	
NAME OF DECEASED <i>John J. Kelly</i>		AGE <i>38</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>March 1, 1918</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
TIME OF DEATH <i>10:30 AM</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>	
PLACE OF BIRTH <i>St. Louis, Mo.</i>		DATE OF BIRTH <i>March 1, 1880</i>		AGE AT DEATH <i>38</i>		SEX AT BIRTH <i>Male</i>	
RACE AT BIRTH <i>White</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		CAUSE OF DEATH <i>Heart Disease</i>	
TIME OF DEATH <i>10:30 AM</i>		DATE OF DEATH <i>March 1, 1918</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
COUNTY <i>Harford</i>		STATE <i>Maryland</i>		COUNTRY <i>United States</i>		WORLD	

CERTIFICATE OF DEATH

Reg. Dist. No.

8281

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 23 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince George's County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wardman Washington D.C. d. STREET ADDRESS 1627 Varnum Place, N.E. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Esther Middle M. Last Kiatta		4. DATE OF DEATH Month July Day 26 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/20/1901
9. AGE (In years last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	
11. BIRTHPLACE (State or foreign country) Lebanon		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Shadid Farrah		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT John H. Kiatta-		Address 1627 Varnum Place, N.E. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Larcenoma adenosarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenosarcoma of right breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 5, 1958 to 7/26/58 , that I last saw the deceased alive on July 25, 1958 , and that death occurred at 12:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3717-38th Ave, Cottage City, Md. DATE SIGNED ACTUAL SIGNATURE George Hageage M.D. PHYSICIAN'S NAME (Type) Dr. George Hageage			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/1958	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.		24a. REC'D BY REGISTRAR JUL 29 '58	
24b. REGISTRAR'S SIGNATURE W. H. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 111

1. NAME OF DECEASED <i>John E. ...</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>1957</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
10. SIGNATURE OF REGISTRAR <i>[Signature]</i>		11. DATE OF REGISTRATION <i>1957</i>		12. OFFICE OF REGISTRAR <i>Baltimore</i>	

RECEIVED
BALTIMORE
MAY 10 1957
MAY 10 1957
MAY 10 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8247

CERTIFICATE OF DEATH

Reg. Dist. No.

08283

1. PLACE OF DEATH o. COUNTY Prince Georges M. Hyattsville				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Washington (8)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carrol Manor				d. STREET ADDRESS 2726 Comm. Ave. N.W.			
3. NAME OF DECEASED (Type or print) First Margaret Middle M. Last Killeen				4. DATE OF DEATH Month 7 Day 5 Year 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/1873	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 7 Days 5 Hours 19 Min. 58		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Recorder of Deeds D.C.		11. BIRTHPLACE (State or foreign country) DISTRICT OF COLUMBIA	
13. FATHER'S NAME GEORGE KILLEEN				14. MOTHER'S MAIDEN NAME MARGARET RILEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -----		17. INFORMANT KATHERINE HART-NEICE Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Accident DUE TO (c) Hypertension Cardio-Vascular Renal Disease Chronic						INTERVAL BETWEEN ONSET AND DEATH one day 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Summer 1940 to July 5th 1958 , that I last saw the deceased alive on July 5th 1958 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank L. Williman M.D.				ADDRESS (Street, city or town, state) 2731 Comm. Ave. N.W. Washington (8) D.C.			
PHYSICIAN'S NAME (Type) Frank L. Williman				DATE SIGNED 7-9-58			
22a. BURIAL DEPOSITED XXXXX (Specify)		22b. DATE THEREOF 7/8/1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler's Sons ADDRESS Washington D.C.				24a. REC'D BY REGISTRAR W. H. Beach DATE JUL 9 '58		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

08284

Reg. Dist. No.

8282

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Georges		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chesley		d. STREET ADDRESS Washington 27 D.C.	
3. NAME OF DECEASED (Type or print) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First Baby Middle Klotz Last Klotz		4. DATE OF DEATH Month July Day 10 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/10/58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 10 Months 10 Days 32
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Raymond Klotz		14. MOTHER'S MAIDEN NAME Elsie Criag	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 8 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/10 1958 , to 7/10 1958 , that I last saw the deceased alive on 7/10 1958 , and that death occurred at 3:35 P.M. , from the causes and on the date stated above.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE John T. Higney		DATE SIGNED 7/11/58	
PHYSICIAN'S NAME (Type) Washington 21, D.C.		M.D. 524187. Barnabas Rd	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF July 12, 1958	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Seatons Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee Wash. D.C.		ADDRESS	
24a. REC'D BY REGISTRAR JUL 15 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the final-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased

2. Sex

3. Age

4. Date of Death

5. Time of Death

6. Place of Death

7. Cause of Death

8. Signature of Registrar

9. Signature of Medical Officer

10. Signature of Coroner

11. Signature of Family Doctor

12. Signature of Nurse

13. Signature of Burial Officer

14. Signature of Registrar

15. Signature of Medical Officer

16. Signature of Coroner

17. Signature of Family Doctor

18. Signature of Nurse

19. Signature of Burial Officer

20. Signature of Registrar

21. Signature of Medical Officer

22. Signature of Coroner

23. Signature of Family Doctor

24. Signature of Nurse

25. Signature of Burial Officer

26. Signature of Registrar

27. Signature of Medical Officer

28. Signature of Coroner

29. Signature of Family Doctor

30. Signature of Nurse

31. Signature of Burial Officer

32. Signature of Registrar

33. Signature of Medical Officer

34. Signature of Coroner

35. Signature of Family Doctor

36. Signature of Nurse

37. Signature of Burial Officer

38. Signature of Registrar

39. Signature of Medical Officer

40. Signature of Coroner

41. Signature of Family Doctor

42. Signature of Nurse

43. Signature of Burial Officer

44. Signature of Registrar

45. Signature of Medical Officer

46. Signature of Coroner

47. Signature of Family Doctor

48. Signature of Nurse

49. Signature of Burial Officer

50. Signature of Registrar

51. Signature of Medical Officer

52. Signature of Coroner

53. Signature of Family Doctor

54. Signature of Nurse

55. Signature of Burial Officer

56. Signature of Registrar

57. Signature of Medical Officer

58. Signature of Coroner

59. Signature of Family Doctor

60. Signature of Nurse

61. Signature of Burial Officer

62. Signature of Registrar

63. Signature of Medical Officer

64. Signature of Coroner

65. Signature of Family Doctor

66. Signature of Nurse

67. Signature of Burial Officer

68. Signature of Registrar

69. Signature of Medical Officer

70. Signature of Coroner

71. Signature of Family Doctor

72. Signature of Nurse

73. Signature of Burial Officer

74. Signature of Registrar

75. Signature of Medical Officer

76. Signature of Coroner

77. Signature of Family Doctor

78. Signature of Nurse

79. Signature of Burial Officer

80. Signature of Registrar

81. Signature of Medical Officer

82. Signature of Coroner

83. Signature of Family Doctor

84. Signature of Nurse

85. Signature of Burial Officer

86. Signature of Registrar

87. Signature of Medical Officer

88. Signature of Coroner

89. Signature of Family Doctor

90. Signature of Nurse

91. Signature of Burial Officer

92. Signature of Registrar

93. Signature of Medical Officer

94. Signature of Coroner

95. Signature of Family Doctor

96. Signature of Nurse

97. Signature of Burial Officer

98. Signature of Registrar

99. Signature of Medical Officer

100. Signature of Coroner

101. Signature of Family Doctor

102. Signature of Nurse

103. Signature of Burial Officer

104. Signature of Registrar

105. Signature of Medical Officer

106. Signature of Coroner

107. Signature of Family Doctor

108. Signature of Nurse

109. Signature of Burial Officer

110. Signature of Registrar

111. Signature of Medical Officer

112. Signature of Coroner

113. Signature of Family Doctor

114. Signature of Nurse

115. Signature of Burial Officer

116. Signature of Registrar

117. Signature of Medical Officer

118. Signature of Coroner

119. Signature of Family Doctor

120. Signature of Nurse

121. Signature of Burial Officer

122. Signature of Registrar

123. Signature of Medical Officer

124. Signature of Coroner

125. Signature of Family Doctor

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127. Signature of Burial Officer

128. Signature of Registrar

129. Signature of Medical Officer

130. Signature of Coroner

131. Signature of Family Doctor

132. Signature of Nurse

133. Signature of Burial Officer

134. Signature of Registrar

135. Signature of Medical Officer

136. Signature of Coroner

137. Signature of Family Doctor

138. Signature of Nurse

139. Signature of Burial Officer

140. Signature of Registrar

141. Signature of Medical Officer

142. Signature of Coroner

143. Signature of Family Doctor

144. Signature of Nurse

145. Signature of Burial Officer

146. Signature of Registrar

147. Signature of Medical Officer

148. Signature of Coroner

149. Signature of Family Doctor

150. Signature of Nurse

151. Signature of Burial Officer

152. Signature of Registrar

153. Signature of Medical Officer

154. Signature of Coroner

155. Signature of Family Doctor

156. Signature of Nurse

157. Signature of Burial Officer

158. Signature of Registrar

159. Signature of Medical Officer

160. Signature of Coroner

161. Signature of Family Doctor

162. Signature of Nurse

163. Signature of Burial Officer

164. Signature of Registrar

165. Signature of Medical Officer

166. Signature of Coroner

167. Signature of Family Doctor

168. Signature of Nurse

169. Signature of Burial Officer

170. Signature of Registrar

171. Signature of Medical Officer

172. Signature of Coroner

173. Signature of Family Doctor

174. Signature of Nurse

175. Signature of Burial Officer

176. Signature of Registrar

177. Signature of Medical Officer

178. Signature of Coroner

179. Signature of Family Doctor

180. Signature of Nurse

181. Signature of Burial Officer

182. Signature of Registrar

183. Signature of Medical Officer

184. Signature of Coroner

185. Signature of Family Doctor

186. Signature of Nurse

187. Signature of Burial Officer

188. Signature of Registrar

189. Signature of Medical Officer

190. Signature of Coroner

191. Signature of Family Doctor

192. Signature of Nurse

193. Signature of Burial Officer

194. Signature of Registrar

195. Signature of Medical Officer

196. Signature of Coroner

197. Signature of Family Doctor

198. Signature of Nurse

199. Signature of Burial Officer

200. Signature of Registrar

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be retained as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AJSME
SM 2/57

8283 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. STREET ADDRESS 5500 M. Street S.E.			
3. NAME OF DECEASED (Type or print) Joseph Raymond Lare				4. DATE OF DEATH Month July Day 15 Year 19 58			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-29-1889	
9. AGE (In years last birthday) 69 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Franklin Lare		14. MOTHER'S MAIDEN NAME Mary Elizabeth Reigner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 579-16-6914		17. INFORMANT Joseph Lare; 811 49th Ave., Capitol Heights, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John J. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-19-58		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc. 517-11 St. A.P.E.				24a. REC'D BY REGISTRAR JUL 18 '58		24b. REGISTRAR'S SIGNATURE W. W. Chambers	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08286

8284

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>	c. LENGTH OF STAY IN 1b <u>2 1/2 hr</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>6512 Queens Chapel Rd</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Dr. Harold H Lavine</u>	4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 Sept. 1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Maurice</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Rose</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>713-383rv3</u>	
17. INFORMANT <u>Sara Lavine</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Labile Hypertension</u> DUE TO (c) <u>Arteriosclerosis - moderate</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> 19 <u>47</u> , to <u>July 28</u> 19 <u>58</u> , that I last saw the deceased alive on <u>July 28</u> 19 <u>58</u> , and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David D. Clayman</u>		ADDRESS (Street, city or town, state) <u>6311 Baltimore Ave - Riverdale, Md</u>	
PHYSICIAN'S NAME (Type) <u>Dr. David Clayman, M.D.</u>		DATE SIGNED <u>7/29/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>7/29-1958</u>	<u>Leisureland Cem.</u>	<u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash. DC</u>		24a. REC'D BY REGISTRAR <u>JUL 29 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Dee Leach</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSM(E)S
SM 9/55

8285

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08287

Item 3. Film G232, 7/31/58 fcy (Per ltr. P.O. Hosp. 7/30/58)

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Washington, D.C. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Choverly, Md.	c. LENGTH OF STAY IN 1b 8 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 3417 - 24th. street, N.E.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Charles J. Linehan	4. DATE OF DEATH Month Day Year 7 - 21 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (State or foreign country) Bradford, Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Patrick A. Linehan		14. MOTHER'S MAIDEN NAME Mary Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Ruth Linehan (Wife) Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9040 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Bronchopneumonia (c) Fractured left hip DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in bedroom at home	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 7-11-1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Washington D.C.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/24/58	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalleys Funeral Home, Inc.		24a. REC'D BY REGISTRAR DATE JUL 25 '58	
ADDRESS mt Ralnia Md		24b. REGISTRAR'S SIGNATURE W. L. Seach	

FOR STATE
HEALTH DEPT.

8286

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08288

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 550 West 171st Street	
3. NAME OF DECEASED (Type or print) George Stanley Litz		4. DATE OF DEATH July 3, 1958	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 23, 1900
9. AGE (in years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. of Laundries		10b. KIND OF BUSINESS OR INDUSTRY Dept. of Correction Brooklyn, N.Y.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Litz		14. MOTHER'S MAIDEN NAME Kathleen Stephens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. 1		16. SOCIAL SECURITY NO. 059-10-4690	
17. INFORMANT Adelaide Litz; same address as # 2.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 3, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 7, 1958	
22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) New York City N. Y.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.	
24a. REC'D BY REGISTRAR JUL 7 '58		24b. REGISTRAR'S SIGNATURE Al. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

continued

402

October 1996

10/10/00

U.S. Dept. of Commerce, Bureau of Economic Warfare, Washington, D.C.

Referral to ...

6892 • J. Neurosci., July 26, 2006 • 26(30):6887–6892

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08289

8253

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 6 1/2 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7240 Glengary Place			d. STREET ADDRESS 7240 Glengary Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Florence Middle Bernice Last Magner			4. DATE OF DEATH Month July Day 7 Year 19 58		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-16		9. AGE (in years last birthday) 41 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Nebraska	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frederick R. Kennedy			14. MOTHER'S MAIDEN NAME Hattie L. McMullen		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address James P. Magner; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442 X DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED July 7, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 10, 1958		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
22d. LOCATION (City, town, or county) Montgomery County, Md.		23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Waller		24. REC'D BY REGISTRAR DATE JUL 10 '58	
24b. REGISTRAR'S SIGNATURE W. J. Smith					

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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• 5. H. von Loh, 7. April.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8287

CERTIFICATE OF DEATH

Reg. Dist. No. 08290

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hosp.</u>				d. STREET ADDRESS <u>14710 St Mary's Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward Alexander Mangis</u>				4. DATE OF DEATH <u>July 4 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-27-81</u>		9. AGE (In years lost birthday) <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>France</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Mangis</u>				14. MOTHER'S MAIDEN NAME <u>Louise Dantz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>hosp. records.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO (c) <u>Rt. Hemiplegia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>undetermined</u> <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>June 27, 1958</u> to <u>July 4, 1958</u> , that I last saw the deceased alive on <u>July 3, 1958</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md.</u> DATE SIGNED <u>July 4, 1958</u>			
PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>							
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Maryland.</u>				24a. REC'D BY REGISTRAR <u>DATE JUL 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08291

Reg. Dist. No.

8288

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. STREET ADDRESS <u>7006 Allison St.</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>E</u> Last <u>Mayhew</u>		4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 Sept. 1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None, Station Attendant, Gasoline</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>ERNEST MAYHEW</u>	
14. MOTHER'S MAIDEN NAME <u>CLARA R. PAGETT</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>217-07-837</u>		17. INFORMANT <u>CLARA R. MAYHEW, 7005 White House Rd. Bowie, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO <u>581.0</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Ascites. Bilateral hydrothorax.</u> (c) <u>Cirrhosis of the liver</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 18th</u> , 19 <u>58</u> , to <u>July 20th</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 20th</u> , 19 <u>58</u> , and that death occurred at <u>4:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>V. S. Bergmann, M.D.</u>		DATE SIGNED <u>July 23 1958</u>	
PHYSICIAN'S NAME (Type) <u>Dr. T. Bergmann, MD.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>7-23-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATIONAL</u>	
22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers & Co. Washington, D. C.</u>	
24a. REC'D BY REGISTRAR <u>JUL 23 1958</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the final-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8289

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Village	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hospital		d. STREET ADDRESS 1714 73rd Place	
3. NAME OF DECEASED (Type or print) Baby Boy McDonough		4. DATE OF DEATH Month July Day 12 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1958
9. AGE (In years last birthday) yrs. 7		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Gersliff T Mc Donough	
14. MOTHER'S MAIDEN NAME Mary Teague		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records Cheverly Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Congenital atelectasis DUE TO Prematurity 1 lb - 3 oz Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 lb - 3 oz DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 hr - 25 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12 July 1958 , 19___, to 12 July , 19 58 , that I last saw the deceased alive on 12 July 1958 , 19___, and that death occurred at 2:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John Kehoe		ADDRESS (Street, city or town, state) Cheverly, Md	
PHYSICIAN'S NAME (Type) Dr. John Kehoe M D		DATE SIGNED 7/14/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/15/58	22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR DATE JUL 17 '58	24b. REGISTRAR'S SIGNATURE Alfred...

2074353XV0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the "Final-Transit" permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

3233

STATE OF MARYLAND

County of _____

City of _____

Ward of _____

Block of _____

Street of _____

Room of _____

Apartment of _____

Building of _____

Tract of _____

Subdivision of _____

Parcel of _____

Lot of _____

Block of _____

Street of _____

Room of _____

Apartment of _____

Building of _____

Tract of _____

Subdivision of _____

Parcel of _____

Lot of _____

Block of _____

Street of _____

Room of _____

Apartment of _____

Building of _____

Tract of _____

Subdivision of _____

Parcel of _____

Lot of _____

FROM

TO

BY

DATE

TIME

PLACE

CAUSE

EVIDENCE

TESTIMONY

VERIFICATION

8323

CERTIFICATE OF DEATH

Reg. Dist. No.

08293

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>		d. STREET ADDRESS <u>829 N. Capitol St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>-</u> Last <u>McDonough</u>		4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/3/86</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printing Pressman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward McDonough</u>		14. MOTHER'S MAIDEN NAME <u>Mary O'Conner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>579-03-5050</u>	
17. INFORMANT <u>Decedent</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>002X</u> IMMEDIATE CAUSE (a) <u>Pulmonary tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>13 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema; cor pulmonale; Chronic brain syndrome</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m. <u>-</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/10</u> , 19 <u>58</u> , to <u>7/29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/29</u> , 19 <u>58</u> , and that death occurred at <u>8:20P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u> DATE SIGNED <u>7/29/58</u>			
ACTUAL SIGNATURE <u>Moe Weiss</u>		M.D. <u>Glenn Dale Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>		<u>Glenn Dale, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8/1/58</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>T. F. Costello</u> ADDRESS <u>1722-N. Capitol St.</u>		24a. REC'D BY REGISTRAR <u>Aug 1 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. J. Beach</u>	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8324 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. LENGTH OF STAY IN TB Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oil City	
3. NAME OF DECEASED (Type or print) Richard First William Middle McIntire Last		4. DATE OF DEATH July Month 8 Day 58 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1933
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Army	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) In service		16. SOCIAL SECURITY NO.	
17. INFORMANT State Police		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 823 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed skull (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an automobile that ran off road and turned over	
20c. TIME OF INJURY Month, Day, Year 2:30 Hour 7/8/ 19 58 p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road	20f. (City or town) (County) (State) Mitchellville P. G. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED July 8, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/11/58	
22c. NAME OF CEMETERY OR CREMATORY Oil City		22d. LOCATION (City, town, or county) (State) Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Cook Inc. Balto -		24. REC'D BY REGISTRAR DATE JUL 14 '58	
24b. REGISTRAR'S SIGNATURE Al. Leach			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
COUNTY OF BALTIMORE

1

2021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: George SURNAME: George

RESIDENCE: 111 1st St CITY: Baltimore STATE: Md

DATE OF DEATH: July 1st 1935 TIME OF DEATH: 10:30 AM

PLACE OF DEATH: Home

CAUSE OF DEATH: Heart Disease

MANNER OF DEATH: Natural

AGE: 45 SEX: Male

RACE: White COLOR OF HAIR: Black

EDUCATION: High School OCCUPATION: Police

STATE POLICE

GRANTED

Occurrence of an automobile crash ran off road and burned over

2:30 PM

James L. Ford

July 1, 1935

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 8290
 CERTIFICATE OF DEATH

08295

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>New York</u> b. COUNTY <u>Richmond</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>3 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Staten Island N.Y.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>				d. STREET ADDRESS <u>15 Lenox Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>McMahon</u> Last <u>McMahon</u>				4. DATE OF DEATH Month <u>7-</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-12-58</u>	
9. AGE (In years last birthday) <u>3 yrs.</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>4</u> Hours <u>15</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Thomas McMahon</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn McMahon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Father - 15 Lenox Place S.I. N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>6 mo gestation</u> DUE TO (c) <u>3 hrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L.W. Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale Ind</u> DATE SIGNED <u>7/12/58</u>			
PHYSICIAN'S NAME (Type) <u>L.W. MALIN</u>				RIVERDALE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>7/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Staten Island NY</u>		22d. LOCATION (City, town, or county) (State) <u>New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> Hyattsville Maryland.				24a. REC'D BY REGISTRAR DATE <u>Jul 17 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Red Gasch</u>	

2076231XVO

CERTIFICATE OF DEATH

2290

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>		AGE <i>35 years</i>		DATE OF BIRTH <i>Jan 15 1890</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>		RACE <i>White</i>		RELIGION <i>Methodist</i>		MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>		OCCUPATION <i>Teacher</i>		RESIDENCE <i>123 Main St. Baltimore, Md.</i>		DATE OF DEATH <i>Jan 20 1925</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		SIGNATURE OF WITNESSES <i>W. J. Brown, M. L. Green</i>		SIGNATURE OF REGISTRAR <i>W. J. Brown</i>		DATE OF REGISTRATION <i>Jan 22 1925</i>		OFFICE OF REGISTRAR <i>Baltimore, Md.</i>	
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RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8291

CERTIFICATE OF DEATH

Reg. Dist. No. 08296

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Miller, Baby Boy		4. DATE OF DEATH July 6 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. 10 min
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald William Miller		14. MOTHER'S MAIDEN NAME Rita Dorothy Calgelia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address 4906 Newton Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 6, 1958 , to July 6, 1958 , that I last saw the deceased alive on July 6, 1958 , at 7:21 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John Kehoe		ADDRESS (Street, city or town, state) 3404 Cheverly Ave. Cheverly, Md.	
PHYSICIAN'S NAME (Type) John Kehoe, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 7/28/58	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly Md		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator		24a. REC'D BY REGISTRAR Aug 5 58	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the final-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077293XVO

CERTIFICATE OF DEATH

1924

DECEASED
NAME
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF PHYSICIAN
SIGNATURE OF REGISTRAR
OFFICIAL USE

1. Name of deceased: _____

2. Age: _____

3. Sex: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Manner of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Official use: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8325 CERTIFICATE OF DEATH

Reg. Dist. No.

08297

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi</u> c. LENGTH OF STAY IN 1b <u>8 wks.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47x-3</u> <u>Adelphi</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pratt Branch Nursing Home</u>				d. STREET ADDRESS <u>1530 Rhode Island</u>			
3. NAME OF DECEASED (Type or print) <u>LOTTIE</u> First <u>MAY</u> Middle <u>MILLER</u> Last				4. DATE OF DEATH <u>July</u> Month <u>16</u> Day <u>1958</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 14, 1867</u> 91 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Christopher Heise</u>				14. MOTHER'S MAIDEN NAME <u>Annie Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Nursing Home records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Longest heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular vascular disease</u> DUE TO <u>disease</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 14, 1958</u> to <u>July 16, 1958</u> , that I last saw the deceased alive on <u>July 14, 1958</u> , and that death occurred at <u>3:00</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lester W. Harris</u> M.D.				ADDRESS (Street, city or town, state) <u>10111 Colesville Road, Silver Spring, Md.</u> DATE SIGNED <u>7-16-58</u>			
PHYSICIAN'S NAME (Type) <u>Lester W. Harris</u>				22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/19/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lester W. Harris</u> ADDRESS <u>2901-14th St. NW, Wash. DC.</u>				24a. REC'D BY REGISTRAR <u>18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Lester W. Harris</u>	

3333 CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. O'NEILL		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1880		5. PLACE OF BIRTH New York	
6. OCCUPATION Carpenter		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. TIME OF DEATH 10:30 AM		10. PLACE OF DEATH Home	
11. SIGNATURE OF PHYSICIAN J. J. O'NEILL		12. SIGNATURE OF DECEASED JAMES J. O'NEILL		13. SIGNATURE OF WITNESS J. J. O'NEILL		14. SIGNATURE OF DECEASED JAMES J. O'NEILL		15. SIGNATURE OF WITNESS J. J. O'NEILL	
16. SIGNATURE OF DECEASED JAMES J. O'NEILL		17. SIGNATURE OF WITNESS J. J. O'NEILL		18. SIGNATURE OF DECEASED JAMES J. O'NEILL		19. SIGNATURE OF WITNESS J. J. O'NEILL		20. SIGNATURE OF DECEASED JAMES J. O'NEILL	
21. SIGNATURE OF DECEASED JAMES J. O'NEILL		22. SIGNATURE OF WITNESS J. J. O'NEILL		23. SIGNATURE OF DECEASED JAMES J. O'NEILL		24. SIGNATURE OF WITNESS J. J. O'NEILL		25. SIGNATURE OF DECEASED JAMES J. O'NEILL	
26. SIGNATURE OF DECEASED JAMES J. O'NEILL		27. SIGNATURE OF WITNESS J. J. O'NEILL		28. SIGNATURE OF DECEASED JAMES J. O'NEILL		29. SIGNATURE OF WITNESS J. J. O'NEILL		30. SIGNATURE OF DECEASED JAMES J. O'NEILL	
31. SIGNATURE OF DECEASED JAMES J. O'NEILL		32. SIGNATURE OF WITNESS J. J. O'NEILL		33. SIGNATURE OF DECEASED JAMES J. O'NEILL		34. SIGNATURE OF WITNESS J. J. O'NEILL		35. SIGNATURE OF DECEASED JAMES J. O'NEILL	
36. SIGNATURE OF DECEASED JAMES J. O'NEILL		37. SIGNATURE OF WITNESS J. J. O'NEILL		38. SIGNATURE OF DECEASED JAMES J. O'NEILL		39. SIGNATURE OF WITNESS J. J. O'NEILL		40. SIGNATURE OF DECEASED JAMES J. O'NEILL	
41. SIGNATURE OF DECEASED JAMES J. O'NEILL		42. SIGNATURE OF WITNESS J. J. O'NEILL		43. SIGNATURE OF DECEASED JAMES J. O'NEILL		44. SIGNATURE OF WITNESS J. J. O'NEILL		45. SIGNATURE OF DECEASED JAMES J. O'NEILL	
46. SIGNATURE OF DECEASED JAMES J. O'NEILL		47. SIGNATURE OF WITNESS J. J. O'NEILL		48. SIGNATURE OF DECEASED JAMES J. O'NEILL		49. SIGNATURE OF WITNESS J. J. O'NEILL		50. SIGNATURE OF DECEASED JAMES J. O'NEILL	
51. SIGNATURE OF DECEASED JAMES J. O'NEILL		52. SIGNATURE OF WITNESS J. J. O'NEILL		53. SIGNATURE OF DECEASED JAMES J. O'NEILL		54. SIGNATURE OF WITNESS J. J. O'NEILL		55. SIGNATURE OF DECEASED JAMES J. O'NEILL	
56. SIGNATURE OF DECEASED JAMES J. O'NEILL		57. SIGNATURE OF WITNESS J. J. O'NEILL		58. SIGNATURE OF DECEASED JAMES J. O'NEILL		59. SIGNATURE OF WITNESS J. J. O'NEILL		60. SIGNATURE OF DECEASED JAMES J. O'NEILL	
61. SIGNATURE OF DECEASED JAMES J. O'NEILL		62. SIGNATURE OF WITNESS J. J. O'NEILL		63. SIGNATURE OF DECEASED JAMES J. O'NEILL		64. SIGNATURE OF WITNESS J. J. O'NEILL		65. SIGNATURE OF DECEASED JAMES J. O'NEILL	
66. SIGNATURE OF DECEASED JAMES J. O'NEILL		67. SIGNATURE OF WITNESS J. J. O'NEILL		68. SIGNATURE OF DECEASED JAMES J. O'NEILL		69. SIGNATURE OF WITNESS J. J. O'NEILL		70. SIGNATURE OF DECEASED JAMES J. O'NEILL	
71. SIGNATURE OF DECEASED JAMES J. O'NEILL		72. SIGNATURE OF WITNESS J. J. O'NEILL		73. SIGNATURE OF DECEASED JAMES J. O'NEILL		74. SIGNATURE OF WITNESS J. J. O'NEILL		75. SIGNATURE OF DECEASED JAMES J. O'NEILL	
76. SIGNATURE OF DECEASED JAMES J. O'NEILL		77. SIGNATURE OF WITNESS J. J. O'NEILL		78. SIGNATURE OF DECEASED JAMES J. O'NEILL		79. SIGNATURE OF WITNESS J. J. O'NEILL		80. SIGNATURE OF DECEASED JAMES J. O'NEILL	
81. SIGNATURE OF DECEASED JAMES J. O'NEILL		82. SIGNATURE OF WITNESS J. J. O'NEILL		83. SIGNATURE OF DECEASED JAMES J. O'NEILL		84. SIGNATURE OF WITNESS J. J. O'NEILL		85. SIGNATURE OF DECEASED JAMES J. O'NEILL	
86. SIGNATURE OF DECEASED JAMES J. O'NEILL		87. SIGNATURE OF WITNESS J. J. O'NEILL		88. SIGNATURE OF DECEASED JAMES J. O'NEILL		89. SIGNATURE OF WITNESS J. J. O'NEILL		90. SIGNATURE OF DECEASED JAMES J. O'NEILL	
91. SIGNATURE OF DECEASED JAMES J. O'NEILL		92. SIGNATURE OF WITNESS J. J. O'NEILL		93. SIGNATURE OF DECEASED JAMES J. O'NEILL		94. SIGNATURE OF WITNESS J. J. O'NEILL		95. SIGNATURE OF DECEASED JAMES J. O'NEILL	
96. SIGNATURE OF DECEASED JAMES J. O'NEILL		97. SIGNATURE OF WITNESS J. J. O'NEILL		98. SIGNATURE OF DECEASED JAMES J. O'NEILL		99. SIGNATURE OF WITNESS J. J. O'NEILL		100. SIGNATURE OF DECEASED JAMES J. O'NEILL	

08298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>PG</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		d. STREET ADDRESS <u>1810 Larch Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Minnie</u> First <u>Mullen</u> Middle <u>Mullen</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russian</u>	11. BIRTHPLACE (State or foreign country) <u>USA</u>
13. FATHER'S NAME <u>Morris</u>		14. MOTHER'S MAIDEN NAME <u>Sophie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Sol Okun</u>		Address <u>810 Larch Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>430.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>360X</u> (b) <u>Interosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus; Carcinoma of Uterine Cervix</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>10 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. f. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>3/12/1958</u> to <u>7/17/1958</u> , that I last saw the deceased alive on <u>7/11/1958</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>5415 Conn. Ave N.W.</u>		ADDRESS (Street, city or town, state) _____ DATE SIGNED _____	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/20-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Capitol Heights Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash. DC</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 21 '58</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8292

CERTIFICATE OF DEATH

08299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, c. LENGTH OF STAY IN 1b 5 Hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor d. STREET ADDRESS 3402 39th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lester Middle H Last Mock		4. DATE OF DEATH Month July Day 8 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/8/02
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Motorman		9b. KIND OF BUSINESS OR INDUSTRY D.C. Transit	
10a. BIRTHPLACE (State or foreign country) Virginia		10b. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. FATHER'S NAME Unk.		12. MOTHER'S MAIDEN NAME Emily Unk.	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		14. SOCIAL SECURITY NO. Lester H. Mock Jr.	
15. INFORMANT Lester H. Mock Jr.		Address Same as No. 2	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombotic Occlusion of the Ant. desc. branch of the left Cor. Ar. DUE TO Arterio Sclerosis of Heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis of Heart (c) Arterio Sclerosis of Heart		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 Jan 54 , to 8 JULY 1958 , that I last saw the deceased alive on 8 JULY 1958 , and that death occurred at 7:10 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cheverly Md DATE SIGNED 7/8/58			
ACTUAL SIGNATURE John Kehoe M.D.		PHYSICIAN'S NAME (Type) Cheverly Md.	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 7/11/58	22c. NAME OF CEMETERY OR CREMATOR Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Francis Hoch's Sons and Hyatt		24a. REC'D BY REGISTRAR JUL 14 58	24b. REGISTRAR'S SIGNATURE Arthur

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8326 CERTIFICATE OF DEATH

Reg. Dist. No. 08300

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PR. GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine Hgts</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 2 - Box 15</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>NAIR</u> Last <u>NAIR</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29-1871</u>
9. AGE (In years last birthday) <u>86</u> yns.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Jackson, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Leander West</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>John L. NAIR</u>		Address <u>Route 2 - Box 15 Brandywine Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Altherosclerotic Cardio-vascular - Renal Disease</u> DUE TO <u> </u> (c) <u>aging process</u> DUE TO <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I attended the deceased from <u>6-15</u> , 19 <u>56</u> to <u>7-12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-12</u> , 19 <u>58</u> , and that death occurred at <u>6 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Dupson</u>		ADDRESS (Street, city or town, state) <u>Brandywine Md.</u> DATE SIGNED <u>7-13-58</u>	
PHYSICIAN'S NAME (Type) <u>Richard H. Dupson</u>		<u>Brandywine Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) <u> </u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Bros.</u> ADDRESS <u>14661 Good Hope Rd SE Wash.</u>		24a. REC'D BY REGISTRAR <u>SUL 15 '58</u> DATE <u> </u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3336

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JANUARY 10, 1900		AT HOME	
AGE		SEX		RACE	
65		Male		White	
BIRTH DATE		BIRTH PLACE		MARRIAGE DATE	
JANUARY 10, 1835		MARYLAND		JANUARY 10, 1855	
FATHER'S NAME		MOTHER'S NAME		EDUCATION	
JAMES H. HARRIS		MARY H. HARRIS		Common School	
OCCUPATION		CAUSE OF DEATH		MEDICAL ATTENDANT	
Farmer		Heart Disease		Dr. J. H. HARRIS	
PREVIOUS ILLNESS		DATE OF BURIAL		PLACE OF BURIAL	
None		JANUARY 12, 1900		CATHOLIC CHURCH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF MINISTER	
James H. Harris		J. H. Harris, M.D.		J. H. Harris, Minister	
DATE OF CERTIFICATE		PLACE OF CERTIFICATE		OFFICE OF VITAL RECORDS	
JANUARY 10, 1900		AT HOME		BALTIMORE, MD.	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND VITAL RECORDS ACT, AND IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8248

Item 2 Film G231 7-11-58 et.

CERTIFICATE OF DEATH

Reg. Dist. No.

08301

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland, D.C. b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 2 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home				e. STREET ADDRESS 2401 Calvert St., N. W. 5805- Queens Chapel Road			
3. NAME OF DECEASED (Type or print) First OLARA Middle B. Last ORTMAN				4. DATE OF DEATH Month July Day 4th. Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 24- 1873	
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Hotel Worker		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Zachary T. Boteler				14. MOTHER'S MAIDEN NAME Hester Tanner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT 7109 - Cabot Street S.E. Mrs. Helen Moore Washington 28, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 465x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis							
INTERVAL BETWEEN ONSET AND DEATH 24 hrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 30, 19 58 to July 4, 19 58 , that I last saw the deceased alive on July 4, 19 58 , and that death occurred at 10:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Habeeb Bacchus M.D.				DATE SIGNED 8602 Farrell Ct. Chevy Chase 41 9/4/58			
PHYSICIAN'S NAME (Type) HABEEB BACCHUS M.D.							
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF July 7-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.				24a. REC'D BY REGISTRAR DATE JUL 7 '58		24b. REGISTRAR'S SIGNATURE W. B. Beach	

STATE DEPARTMENT OF HEALTH-BALTIMORE 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8293

CERTIFICATE OF DEATH

Reg. Dist. No.

08302

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 4700 Cooper Lane	
3. NAME OF DECEASED (Type or print) First Jessie Middle M. Last Peterson				4. DATE OF DEATH Month July Day 21 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-21-10		9. AGE (In years lost birthday) 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Washington DC	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Solomon Curtis			
14. MOTHER'S MAIDEN NAME Gertrude M. Austin				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Carly C. Peterson Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330x DUE TO Intercranial hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured aneurysm - Circle of Willis DUE TO (c) 13 days INTERVAL BETWEEN ONSET AND DEATH 13 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 19 Jul 1958 to 21 Jul 1958 , that I last saw the deceased alive on 21 Jul 1958 , and that death occurred at 9:20 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Thomas G. Maloney MD		ADDRESS (Street, city or town, state) 4814-71st Ave		DATE SIGNED 22 Jul 58	
PHYSICIAN'S NAME (Type) Dr. T. Maloney		NAME OF CEMETERY OR CREMATORY George Washington Biggs Rd. Hyattsville, Md			
22b. DATE THEREOF 7/25/58		22d. LOCATION (City, town, or county) Hyattsville, Md		24a. REC'D BY REGISTRAR DATE JUL 25 '58	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.		ADDRESS mt. Rainier, Md.		24b. REGISTRAR'S SIGNATURE Albert Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8327

PRINCE GEORGE'S
CERTIFICATE OF DEATH

Reg. Dist. No.

08303

1. PLACE OF DEATH a. COUNTY <u>Cleves Cedars Rest Home</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>P. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11012 Mont. Rd. Beltsville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>University Park, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges</u>		d. STREET ADDRESS <u>4316 Sheridan St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clara B. Potter</u>		4. DATE OF DEATH <u>July 2, 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 5, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Federal Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John D. Baker</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Eleanor Bixler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs Audrey Potter Shippen University Park Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension, cerebral accident</u> DUE TO (c) <u>generalized arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>7d hrs</u> <u>3 weeks</u> <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19, 1958</u> to <u>July 2, 1958</u> , that I last saw the deceased alive on <u>July 2, 1958</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Mathias</u>		ADDRESS (Street, city or town, state) <u>2200 R.I. Ave NE, Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Thos. E. Mathias</u>		DATE SIGNED <u>July 5, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7/5/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Newport</u>		22d. LOCATION (City, town, or county) (State) <u>Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	
DATE <u>JUL 7 '58</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. MEDICAL HISTORY		11. PRESENT ILLNESS		12. TREATMENT	
13. HISTORY OF PRESENT ILLNESS		14. PHYSICIAN'S SIGNATURE		15. DATE	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF DECEASED'S NEAREST RELATIVE		18. SIGNATURE OF WITNESSES	
19. SIGNATURE OF DECEASED'S NEAREST RELATIVE		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
22. SIGNATURE OF WITNESSES		23. SIGNATURE OF DECEASED'S NEAREST RELATIVE		24. SIGNATURE OF WITNESSES	
25. SIGNATURE OF DECEASED'S NEAREST RELATIVE		26. SIGNATURE OF WITNESSES		27. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
28. SIGNATURE OF WITNESSES		29. SIGNATURE OF DECEASED'S NEAREST RELATIVE		30. SIGNATURE OF WITNESSES	
31. SIGNATURE OF DECEASED'S NEAREST RELATIVE		32. SIGNATURE OF WITNESSES		33. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
34. SIGNATURE OF WITNESSES		35. SIGNATURE OF DECEASED'S NEAREST RELATIVE		36. SIGNATURE OF WITNESSES	
37. SIGNATURE OF DECEASED'S NEAREST RELATIVE		38. SIGNATURE OF WITNESSES		39. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
40. SIGNATURE OF WITNESSES		41. SIGNATURE OF DECEASED'S NEAREST RELATIVE		42. SIGNATURE OF WITNESSES	
43. SIGNATURE OF DECEASED'S NEAREST RELATIVE		44. SIGNATURE OF WITNESSES		45. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
46. SIGNATURE OF WITNESSES		47. SIGNATURE OF DECEASED'S NEAREST RELATIVE		48. SIGNATURE OF WITNESSES	
49. SIGNATURE OF DECEASED'S NEAREST RELATIVE		50. SIGNATURE OF WITNESSES		51. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
52. SIGNATURE OF WITNESSES		53. SIGNATURE OF DECEASED'S NEAREST RELATIVE		54. SIGNATURE OF WITNESSES	
55. SIGNATURE OF DECEASED'S NEAREST RELATIVE		56. SIGNATURE OF WITNESSES		57. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
58. SIGNATURE OF WITNESSES		59. SIGNATURE OF DECEASED'S NEAREST RELATIVE		60. SIGNATURE OF WITNESSES	
61. SIGNATURE OF DECEASED'S NEAREST RELATIVE		62. SIGNATURE OF WITNESSES		63. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
64. SIGNATURE OF WITNESSES		65. SIGNATURE OF DECEASED'S NEAREST RELATIVE		66. SIGNATURE OF WITNESSES	
67. SIGNATURE OF DECEASED'S NEAREST RELATIVE		68. SIGNATURE OF WITNESSES		69. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
70. SIGNATURE OF WITNESSES		71. SIGNATURE OF DECEASED'S NEAREST RELATIVE		72. SIGNATURE OF WITNESSES	
73. SIGNATURE OF DECEASED'S NEAREST RELATIVE		74. SIGNATURE OF WITNESSES		75. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
76. SIGNATURE OF WITNESSES		77. SIGNATURE OF DECEASED'S NEAREST RELATIVE		78. SIGNATURE OF WITNESSES	
79. SIGNATURE OF DECEASED'S NEAREST RELATIVE		80. SIGNATURE OF WITNESSES		81. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
82. SIGNATURE OF WITNESSES		83. SIGNATURE OF DECEASED'S NEAREST RELATIVE		84. SIGNATURE OF WITNESSES	
85. SIGNATURE OF DECEASED'S NEAREST RELATIVE		86. SIGNATURE OF WITNESSES		87. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
88. SIGNATURE OF WITNESSES		89. SIGNATURE OF DECEASED'S NEAREST RELATIVE		90. SIGNATURE OF WITNESSES	
91. SIGNATURE OF DECEASED'S NEAREST RELATIVE		92. SIGNATURE OF WITNESSES		93. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
94. SIGNATURE OF WITNESSES		95. SIGNATURE OF DECEASED'S NEAREST RELATIVE		96. SIGNATURE OF WITNESSES	
97. SIGNATURE OF DECEASED'S NEAREST RELATIVE		98. SIGNATURE OF WITNESSES		99. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
100. SIGNATURE OF WITNESSES		101. SIGNATURE OF DECEASED'S NEAREST RELATIVE		102. SIGNATURE OF WITNESSES	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MASS.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08304

8294

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riversdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 West Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Prince Georgie OLENA Price</u>				4. DATE OF DEATH <u>7 (July) - 7 - 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-14-1894</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner of Rooming House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William A. Lowe</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Husband - 1906 Oliver St. Hyattsville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart dis</u> <u>5 yrs.</u> (c) <u>Hypertension</u> <u>5 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 5, 1958</u> , to <u>July 7, 1958</u> , that I last saw the deceased alive on <u>July 6, 1958</u> , and that death occurred at <u>12:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Nealen M.D.</u>				ADDRESS (Street, city or town, state) <u>Riversdale, Md.</u> DATE SIGNED <u>7/7/58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-10-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber C. Inc.</u> ADDRESS <u>517-11 St. E.</u>				24a. REC'D BY REGISTRAR <u>JUL 9 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. W. Chamber</u>	

8328

CERTIFICATE OF DEATH

108305
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>			
c. LENGTH OF STAY IN 1b <u>1 yr., 8 mos., & 14 days.</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>130 48th Place, N. E.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Abe</u> Middle <u>-</u> Last <u>Rand, Jr.</u>				4. DATE OF DEATH Month <u>7</u> Day <u>23</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/6/26</u>	
9. AGE (In years last birthday) yrs. <u>32</u>		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>		IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>X-ray technician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dr. V. Wilkerson</u>		11. BIRTHPLACE (State or foreign country) <u>Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Rand</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Cheatham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>486-26-5536</u>		17. INFORMANT <u>Decedent</u>	
Address <u>-</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left thoracoplasty performed in 1947; cor pulmonale</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>-</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/9</u> , 19 <u>56</u> , to <u>7/23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/22</u> , 19 <u>58</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Moe Weiss</u>				ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u> DATE SIGNED <u>7/23/58</u>			
PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>				<u>Glenn Dale, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE TIME OF <u>7-23-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wheatley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malvan & Schee</u> ADDRESS <u>424 R St. N.W.</u>				24a. REC'D BY REGISTRAR <u>7/23/58</u>		24b. REGISTRAR'S SIGNATURE <u>Moe Weiss</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1928

<p>NAME OF DECEASED [Faint text]</p>		<p>AGE [Faint text]</p>		<p>SEX [Faint text]</p>		<p>RACE [Faint text]</p>	
<p>DATE OF DEATH [Faint text]</p>		<p>TIME OF DEATH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>		<p>CITY [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>MANNER OF DEATH [Faint text]</p>		<p>EDUCATION [Faint text]</p>		<p>OCCUPATION [Faint text]</p>	
<p>DATE OF BIRTH [Faint text]</p>		<p>PLACE OF BIRTH [Faint text]</p>		<p>CITY OF BIRTH [Faint text]</p>		<p>STATE OF BIRTH [Faint text]</p>	
<p>DATE OF MARRIAGE [Faint text]</p>		<p>PLACE OF MARRIAGE [Faint text]</p>		<p>CITY OF MARRIAGE [Faint text]</p>		<p>STATE OF MARRIAGE [Faint text]</p>	
<p>DATE OF DEATH [Faint text]</p>		<p>TIME OF DEATH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>		<p>CITY [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>MANNER OF DEATH [Faint text]</p>		<p>EDUCATION [Faint text]</p>		<p>OCCUPATION [Faint text]</p>	
<p>DATE OF BIRTH [Faint text]</p>		<p>PLACE OF BIRTH [Faint text]</p>		<p>CITY OF BIRTH [Faint text]</p>		<p>STATE OF BIRTH [Faint text]</p>	
<p>DATE OF MARRIAGE [Faint text]</p>		<p>PLACE OF MARRIAGE [Faint text]</p>		<p>CITY OF MARRIAGE [Faint text]</p>		<p>STATE OF MARRIAGE [Faint text]</p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8249

CERTIFICATE OF DEATH

Reg. Dist. No.

08306

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. LENGTH OF STAY IN 1b 40 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5104 41th avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Bernard Middle Reese Last Jr		4. DATE OF DEATH Month July Day 2 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Geologist		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John B Reese		14. MOTHER'S MAIDEN NAME Florence Feathers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W W 1	
17. INFORMANT Adelaide C Reese		Address Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Coronary Arteries DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from July 13, 1958 to July 2, 1958 , that I last saw the deceased alive on July 2, 1958 , and that death occurred at 1:05 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE E. Herbert Bauersfeld M.D. 1912 E. S. W. Washington DC DATE SIGNED 7/2/58 PHYSICIAN'S NAME (Type) E. Herbert Bauersfeld			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 7, 1958	
22c. NAME OF CEMETERY OR INTERMENT Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE JUL 7 '58	
ADDRESS Hyattsville Md.		24b. REGISTRAR'S SIGNATURE Gasch's Sons	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

8295

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08307
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 East Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5707 64th Place	
3. NAME OF DECEASED (Type or print) William Curtis Reisinger		4. DATE OF DEATH July 29 1958	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-25-52
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Curtis Reisinger, Sr.		14. MOTHER'S MAIDEN NAME Dorothy Mary Ryan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Wm. C. Reisinger; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowning	
20c. TIME OF INJURY Month. Day. Year 10.30 a.m. 7-29-58 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) stream		20f. (City or town) (County) (State) E. Riverdale Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 29, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-1-58	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS WASH. D.C. 3821 14th. St. N.W.	
24a. REC'D BY REGISTRAR DATE AUG 1 '58		24b. REGISTRAR'S SIGNATURE Alfred	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be retained as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8329

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>FORESTVILLE, MD</u> <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>PR. GEO.</u> b. COUNTY <u>PR. GEO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE, MD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE, MD</u>		c. LENGTH OF STAY IN 1b <u>24 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOME</u>		d. STREET ADDRESS <u>3710-82nd Ave, SE</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES JOHN REISSER</u>		4. DATE OF DEATH <u>JULY 15 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 MARCH 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>METALLIC LATHER BUILDING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HARRISBURG, PA.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES REISSER</u>		14. MOTHER'S MAIDEN NAME <u>OTTILIA WITMORE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>519-284311</u>	
17. INFORMANT <u>WIFE - MRS. BERTHA REISSER</u>		Address <u>3710-82ND AVE FORESTVILLE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Acute Congestive Failure</u> DUE TO <u>MYOCARDIAL INSUFFICIENCY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE ARTERIOSCLEROSIS</u> DUE TO (c) <u>3-4 yrs. 10-15 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BILAT. INGUINAL HERNIAS.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 13</u> , 19 <u>58</u> , to <u>July 15</u> , 19 <u>58</u> that I last saw the deceased alive on <u>13 July</u> , 19 <u>58</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>7200 MARLBORO PIKE SE. M.D.</u>		DATE SIGNED <u>JUL 17 1958</u>	
ACTUAL SIGNATURE <u>Adwney W. Lowery</u>		PHYSICIAN'S NAME (Type) <u>S. W. LOWERY M.D. WASH. 28 D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried July 18-58</u>		22b. DATE THEREOF <u>July 18-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Edgar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>		ADDRESS <u>1661-9th Hope Rd SE Wash DC</u>	
24a. REC'D BY REGISTRAR <u>1111</u>		24b. REGISTRAR'S SIGNATURE <u>Outland</u>	
DATE <u>JUL 17 1958</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use at the funeral-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8829

DECEASED - NAME AND ADDRESS		DATE OF DEATH	
JAMES EARL RAY, JR. 1000 N. W. 10th St. Miami, Fla.		April 4, 1968	
AGE		SEX	
34 years		Male	
RACE		EDUCATION	
White		High School	
OCCUPATION		CAUSE OF DEATH	
Actor		Myocardial Infarction	
PLACE OF DEATH		MANNER OF DEATH	
Home		Natural	
Physician		Hospital	
Dr. J. Edgar Hoover		St. Vincent's Hospital	
Signature		Date	
[Signature]		April 4, 1968	
Registrar		County	
[Signature]		Dade County, Fla.	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8296 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS "Rose Mont"		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Alice Jay Roberts			4. DATE OF DEATH Month July Day 21 Year 1958		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-73		9. AGE (In years last birthday) 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Tobacco)		10b. KIND OF BUSINESS OR INDUSTRY Farming (Own)		11. BIRTHPLACE (State or foreign country) Landover, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Williams Roberts			14. MOTHER'S MAIDEN NAME Elesa Weems		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mema R. Prentice; same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 917.0 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia DUE TO (c) 2nd and 3rd degree burns of body					INTERVAL BETWEEN ONSET AND DEATH 48 hours 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped on stairs while carrying a kettle of hot water.			
20c. TIME OF INJURY Month, Day, Year 11 Hour XX p. m. 7-11 1958		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
		20f. (City or town) Landover		(County) Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		July 21, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/58		22c. NAME OF CEMETERY OR CREMATORY Cemetery St. Barnabas Episcopal Leland, Pr. Geo's-Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-Marlboro, Md.		ADDRESS Upper		24a. REC'D BY REGISTRAR DATE JUL 28 '58	
				24b. REGISTRAR'S SIGNATURE <i>Al. H. ...</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be retained as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8236

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be retained as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8297

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08311

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> 83x-3 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. STREET ADDRESS <u>914 - Clemson Blvd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Russell Roberts</u>		4. DATE OF DEATH Month Day Year <u>JULY 26 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 22, 1897</u> 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Solider</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Ronan Roberts</u>		14. MOTHER'S MARRIAGE NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>578-18-7932</u>	
17. INFORMANT <u>Russell M Roberts, same as #1</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive pontine hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Right cerebral thrombosis</u> (a), stating the underlying cause last. (c) <u>cerebral arterio sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. DATE SIGNED <u>July 28, 1958</u>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-30-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl</u>		22d. LOCATION (City, town, or county) (State) <u>Ft Myer, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Chomkowski, Inc.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 31 '58</u>	
ADDRESS <u>1400 Channing St NW Wash. D.C. 1</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Chomkowski</u>	

FOR STATE
ATTENDANCE

NOTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
6207 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: John Doe

2. SEX: Male

3. AGE: 45

4. DATE OF DEATH: 10-15-1962

5. TIME OF DEATH: 10:00 AM

6. PLACE OF DEATH: Home

7. CAUSE OF DEATH: Myocardial Infarction

8. MANNER OF DEATH: Natural

9. SIGNATURE OF EXAMINER: [Signature]

10. DATE OF SIGNATURE: 10-16-1962

11. ADDRESS OF EXAMINER: 123 Main St, Baltimore, MD

12. TELEPHONE: 555-1234

13. HOSPITAL: None

14. PHYSICIAN: Dr. J. Smith

15. NURSE: None

16. OTHER: None

17. SIGNATURE OF PHYSICIAN: [Signature]

18. DATE OF SIGNATURE: 10-15-1962

19. ADDRESS OF PHYSICIAN: 456 Oak St, Baltimore, MD

20. TELEPHONE: 555-5678

21. SIGNATURE OF NURSE: [Signature]

22. DATE OF SIGNATURE: 10-15-1962

23. ADDRESS OF NURSE: 789 Pine St, Baltimore, MD

24. TELEPHONE: 555-9012

25. SIGNATURE OF OTHER: [Signature]

26. DATE OF SIGNATURE: 10-15-1962

27. ADDRESS OF OTHER: 101 Elm St, Baltimore, MD

28. TELEPHONE: 555-3456

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8330

CERTIFICATE OF DEATH

Reg. Dist. No. 08312

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Utah b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marlow Heights		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) 6312 St. Clair Drive		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Layton 81X-3 ✓	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 350 Knowlton Street	
3. NAME OF DECEASED (Type or print) First Hugh Middle Robert Last Roberts		4. DATE OF DEATH Month July Day 1 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/1876
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-- Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Logan, Utah		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert David Roberts		14. MOTHER'S MAIDEN NAME Hannah Roberts Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -- (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. 528-32-4807	
17. INFORMANT Mrs. Annie B. Roberts		Address 350 Knowlton St. Layton, Utah	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinomatosis, primary site probably lung.			INTERVAL BETWEEN ONSET AND DEATH 7 days Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/28 , 1958, to 6/30 , 1958, that I last saw the deceased alive on 6/30 , 1958, and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE John T. Lynn		ADDRESS (Street, city or town, state) 5241 St. Barnabas Rd. S.E. DATE SIGNED 7/1/58 De.	
PHYSICIAN'S NAME (Type) John T. Lynn			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 7/1/58	22c. NAME OF CEMETERY OR CREMATORY Logan Cemetery	22d. LOCATION (City, town, or county) (State) Logan, Utah
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St. N.W. Wash. D.C.		24a. REC'D BY REGISTRAR JUL 2 24b. REGISTRAR'S SIGNATURE W. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the official-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

1. 0. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8331

CERTIFICATE OF DEATH

Reg. Dist. No. 08313

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Prince Georges Co MD</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>DC</i> b. COUNTY <i>Washington</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington DC</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington DC</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <i>none</i> | | d. STREET ADDRESS <i>47X-3</i> | |
| 3. NAME OF DECEASED
(Type or print) <i>HERBERT JAMES RUCKER</i> | | 4. DATE OF DEATH <i>July 29th 1958</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Colored</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>October 17, 1908</i> |
| 9. AGE (In years last birthday) <i>49</i> yrs. | | IF UNDER 1 YEAR: Months <i>9</i> Days <i>12</i> Hours <i>12</i> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lather</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Building Industry</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Washington DC USA</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>Pleasant Henry Rucker</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Lou Lowry</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give word or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Frank Milton Rucker Brother</i> | | Address <i>241 Hillside Pl D.C.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Insufficiency</i>
422.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Unknown</i>
DUE TO (c) <i>Unknown</i> | | | INTERVAL BETWEEN ONSET AND DEATH
<i>3 months 24 days</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>April 5, 1958</i> , to <i>July 21st, 1958</i> , that I last saw the deceased alive on <i>July 21st, 1958</i> , and that death occurred at <i>10:50 P.M.</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Simeon P. Austin</i> M.D. | | ADDRESS (Street, city or town, state) <i>702 S. St N.W.</i> DATE SIGNED <i>7/30/58</i> | |
| PHYSICIAN'S NAME (Type) <i>SIMEON P. T. AUSTIN M.D.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>8-2-58</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Mem. Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert M. Quinn</i> | | 24a. REC'D BY REGISTRAR <i>1220 9th</i> DATE <i>AUG 1 58</i> | |
| 24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the final-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2231

71

Brother

11

11

28 July 1918

11:15 PM

102 2 21 1918

11/18

SIMON B. T. HUSTON MD.

Robert B. Huston

July 21st 28

Baltimore, Maryland

City of Baltimore

1918

8298

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>GREENBELT</u> | | | | c. LENGTH OF STAY IN 1b
<u>3 YRS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u># 2 - LAKE SIDE DRIVE</u> | | | | d. STREET ADDRESS
<u>1# 2 - LAKE SIDE DRIVE</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>JOHN MICHAEL RYAN</u> | | | | 4. DATE OF DEATH Month Day Year
<u>JULY 9 19 58</u> | | | |
| 5. SEX
<u>MALE</u> | | 6. COLOR OR RACE
<u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. B. DATE OF BIRTH
<u>JULY 10 1907</u> | |
| 9. AGE (In years lost birthday) yrs.
<u>50</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>INFORMATION SPECIALIST</u> | | 11. BIRTHPLACE (State or foreign country)
<u>PLANKINTON, S.D.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>JOSEPH RYAN</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MARY BRAY</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT Address
<u>ANN M. RYAN - #2 - LAKE SIDE DR GREENBELT, MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>200.1</u> DUE TO <u>lymphosarcoma</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour o. 11. p. m. Month, Day, Year
<u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 24, 1958</u> , to <u>July 9, 1958</u> , that I last saw the deceased alive on <u>July 8, 1958</u> , and that death occurred at <u>7:19 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Hans Wodak</u> | | | | ADDRESS (Street, city or town, state)
<u>30-C RIDGE RD GREENBELT, MD</u> | | | |
| DATE SIGNED
<u>7-9-58</u> | | | | | | | |
| PHYSICIAN'S NAME (Type)
<u>HANS WODAK M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>7/12/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>MT OLIVET CEM.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>WASHINGTON, D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W.W. Charles Co - Bethesda, Md.</u> | | | | ADDRESS
<u>Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>JUL 11 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>W. W. Charles</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the final-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8299

CERTIFICATE OF DEATH

08315

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges Ann Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
7 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Tracey Landing ✓ |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Prince Georges General Hospital | | d. STREET ADDRESS
None | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Thomas Middle Savoy Last Savoy | | 4. DATE OF DEATH
Month July Day 11 Year 58 | |
| 5. SEX
Male | 6. COLOR OR RACE
Black | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
?? |
| 9. AGE (In years last birthday)
44 yrs. | | IF UNDER 1 YEAR: Months 11 Days 19 Hours 58 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
? | |
| 14. MOTHER'S MAIDEN NAME
? | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Sophia Savoy Tracey Landing Md. Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal failure
DUE TO 445x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) benign nephrosclerosis
DUE TO Malignant Hypertension
(c) ? | | | INTERVAL BETWEEN ONSET AND DEATH
? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. 19 p. m. | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July 4, 1958 , to July 11, 1958 , that I last saw the deceased alive on July 11, 1958 , and that death occurred at 12 20 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
William D. Rosson M.D. | | ADDRESS (Street, city or town, state)
5304 Annapolis Road | |
| PHYSICIAN'S NAME (Type)
Dr. William D. Rosson | | Bladensburg, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF
7-14-58 | 22c. NAME OF CEMETERY OR CREMATORY
Mosses Crest | 22d. LOCATION (City, town, or county) (State)
Bladensburg, Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. G. Goss, Annapolis Md | | 24a. REC'D BY REGISTRAR
Dr. Goss | |
| 24b. REGISTRAR'S SIGNATURE
Dr. Goss | | DATE JUL 14 '58 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the official transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8300

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince George's General | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Schmidt Baby Boy | | 4. DATE OF DEATH July 3 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 3 1958 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) yrs. 10 5 Min. 5 |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Fredrick J. Schmidt | | 14. MOTHER'S MAIDEN NAME Patricia Hodges | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Hospital records | | Address Cheverly Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
762.5 IMMEDIATE CAUSE (a) atelectasis
DUE TO Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atelectasis
DUE TO (c) Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 2 July 1958 to 2 July 1958 that I last saw the deceased alive on 2 July 1958 and that death occurred at 11:35 P.M. from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE John W. Perkins | | DATE SIGNED 7/3/58 | |
| PHYSICIAN'S NAME (Type) John W. Perkins M. D. | | ADDRESS (Street, city or town, state) 5301 Hamilton St. Hyattsville, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 7/5/58 | 22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery | 22d. LOCATION (City, town, or county) (State) Washington D. C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | ADDRESS Hyattsville Md. | |
| 24a. REC'D BY REGISTRAR JUL 7 '58 | | 24b. REGISTRAR'S SIGNATURE W. Leach | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8332

CERTIFICATE OF DEATH

08317

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's Co. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo's Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Accokeek Suitland | | c. LENGTH OF STAY IN 1b
1 Month | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Suitland Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ELFROSINA | | 4. DATE OF DEATH July 31 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 10th. 1890 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | |
| 11. BIRTHPLACE (State or foreign country)
Romania | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Vaslie Bacla | | 14. MOTHER'S MAIDEN NAME
Mary ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service: <input type="checkbox"/> | | 16. SOCIAL SECURITY NO. <input type="checkbox"/> | |
| 17. INFORMANT Nicholas Serbu | | Address Same as # 2. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive Heart Failure
DUE TO Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <input type="checkbox"/> DUE TO
(c) <input type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH
4 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July 28, 1958 to July 31, 1958 , that I last saw the deceased alive on July 30, 1958 , and that death occurred at 3 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Lawrence D. Summerfield | | ADDRESS (Street, city or town, state) 1400- Branch Ave., S.E. Wash., DC | |
| PHYSICIAN'S NAME (Type) Lawrence D. Summerfield | | DATE SIGNED 7/31/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | 22b. DATE THEREOF
Aug. 1st 58 | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | 22d. LOCATION (City, town, or county) (State)
Suitland, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros | | 24a. REC'D BY REGISTRAR W. J. ... | |
| ADDRESS 1661- Good Hope Rd. S.E. Washington 20, D.C. | | DATE AUG 4 '58 | |

CERTIFICATE OF DEATH

2335

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| <p>1. NAME OF DECEASED
 John Doe</p> | | <p>2. SEX
 Male</p> | | <p>3. AGE
 45</p> | | <p>4. DATE OF BIRTH
 Jan 1, 1900</p> | | <p>5. PLACE OF BIRTH
 Baltimore, Md.</p> | |
| <p>6. OCCUPATION
 Teacher</p> | | <p>7. MARITAL STATUS
 Married</p> | | <p>8. DATE OF DEATH
 Dec 15, 1945</p> | | <p>9. PLACE OF DEATH
 Home</p> | | <p>10. CAUSE OF DEATH
 Heart Disease</p> | |
| <p>11. SIGNATURE OF DECEASED
 John Doe</p> | | <p>12. SIGNATURE OF WITNESS
 John Doe</p> | | <p>13. SIGNATURE OF PHYSICIAN
 John Doe</p> | | <p>14. SIGNATURE OF CORONER
 John Doe</p> | | <p>15. SIGNATURE OF REGISTRAR
 John Doe</p> | |
| <p>16. NAME OF FUNERAL HOME
 John Doe</p> | | <p>17. ADDRESS OF FUNERAL HOME
 John Doe</p> | | <p>18. CITY OF FUNERAL HOME
 Baltimore</p> | | <p>19. STATE OF FUNERAL HOME
 Md.</p> | | <p>20. ZIP CODE OF FUNERAL HOME
 21201</p> | |

CERTIFICATE OF DEATH

Reg. Dist. No.

08318

8301

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chesapeake Cheverly | | c. LENGTH OF STAY IN 1b
1 Month 22 d | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Prince Georges General Hospital | | d. STREET ADDRESS
Box 390 | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Elizabeth Sheaks A. Sheaks | | 4. DATE OF DEATH
Month Day Year
July 22 19 58 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 15, 1880 |
| 9. AGE (In years last birthday)
78 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Jacob Reinoehl | | 14. MOTHER'S MAIDEN NAME
Carry Miller | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
-- | |
| 17. INFORMANT
Sadie Shoop | | Address
Box 390 Clinton, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma to Lungs and Mediastinum
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of the Right Breast
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
6 months
1 year | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5/28/58 , 19 58 , to 7/22/58 , 19 58 , that I last saw the deceased alive on 7/22 , 19 58 , and that death occurred at 2:05P M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
5304 Annapolis Road 7/23/58
Bladensburg, Maryland | | | |
| ACTUAL SIGNATURE William D. Rosson M.D. | | PHYSICIAN'S NAME (Type) William D. Rosson, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7/25/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Washington National Cem: | | 22d. LOCATION (City, town, or county) (State)
Suitland Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ritchie Bros. Funeral Home | | ADDRESS
Upper Marlboro, Md. | |
| 24a. REC'D BY REGISTRAR
JUL 28 '58 | | 24b. REGISTRAR'S SIGNATURE
W. H. Search | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000 1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8302

CERTIFICATE OF DEATH

08319

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cheverly</u> | | c. LENGTH OF STAY IN 1b
<u>13 hr</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Prince Georges General Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Harry</u> Middle <u>C.</u> Last <u>Shearer</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>28</u> Year <u>19 58</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>14 Sept. 1892</u> |
| 9a. AGE (In years last birthday)
<u>65</u> yrs. | | 9b. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Plaster</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Construction</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Oscar Shearer</u> | | 14. MOTHER'S MAIDEN NAME
<u>Margaret Sullivan</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes, give year or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>579 01 5496</u> | |
| 17. INFORMANT
<u>Iva B. Shearer</u> | | Address
<u>As 2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. <u> </u> p. m. <u> </u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>25 July</u> , 19 <u>58</u> , to <u>27 July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>27 July</u> , 19 <u>58</u> , and that death occurred at <u>11:30 A.</u> M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Dr. M. Hutchins</u> | | ADDRESS (Street, city or town, state) <u>7315 Janderson Rd. Hyattsville, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Dr. Thoams M Hutchins MD</u> | | DATE SIGNED <u>1-28-58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>July 30</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Flower Hill</u> | 22d. LOCATION (City, town, or county) (State)
<u>Redland Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Ray W Barber</u> | | ADDRESS
<u>Laytonsville, Md</u> | |
| 24a. REC'D BY REGISTRAR
DATE <u>JUL 30 '58</u> | | 24b. REGISTRAR'S SIGNATURE
<u>W. E. Seach</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the final-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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no doubt.

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1995年12月 120000

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

452

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8251

CERTIFICATE OF DEATH

Item 17, Film G-232 8/8/58

Reg. Dist. No. 08320

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>PRINCE GEORGE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>D. C.</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR HOME</u> | | | | d. STREET ADDRESS <u>1538 MONROE ST. N.W.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>A.</u> Last <u>SHOEMAKER</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 5, 1883</u> 75 yrs. | |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALEMAN RET.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years lost birthday) <u>75</u> yrs. | |
| 11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Unk</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unk</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>578-07-300</u> | | 17. INFORMANT <u>Bernard</u> 5810 <u>Bald. Md.</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cancer of Stomach & Metastases</u>
<u>151X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH <u>four months plus</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. ft. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>July 28</u> , 19 <u>58</u> , to <u>July 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 28</u> , 19 <u>58</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Neil P. Campbell</u> | | | | ADDRESS (Street, city or town, state) <u>3060-16th St Wash DC</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Neil P. Campbell</u> | | | | DATE SIGNED <u>7/28/58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>Aug 1-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Leason</u> ADDRESS <u>Wash. D.C.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUL 30 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Willie</u> | |

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8333

CERTIFICATE OF DEATH

Reg. Dist. No.

08321

| | | | | | | | |
|--|--------------------|--|---------------------------|---|---------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Hill | | c. LENGTH OF STAY IN 1b Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Chapel Hill, Maryland | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS 9148-Old Fort Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last JAMES HENRY SHORTER | | | | 4. DATE OF DEATH Month 7 Day 11 Year 1958 | | | |
| 5. SEX M | 6. COLOR OR RACE C | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-1-1874 | 9. AGE (In years last birthday) 84 yrs. | IF UNDER 1 YEAR Months 2 Days 2 | IF UNDER 24 HRS. Hours 2 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED | | 11. BIRTHPLACE (State or foreign country) Chapel Hill, MD. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ALBERT SHORTER | | | | 14. MOTHER'S MAIDEN NAME SARAH BROWN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address MRS. CLARA PLUMMER - SAME - | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Myocardial Infarction
DUE TO atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis and Coronary Artery Disease
DUE TO (c) Aging
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 Days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 7-9 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5-15, 1956, to 7-11, 1958, that I last saw the deceased alive on 7-9, 1958, and that death occurred at 10:05 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Richard H. Danson M.D. | | | | Richard H. Danson, MD | | | |
| PHYSICIAN'S NAME (Type) Richard H. Danson | | | | Richard H. Danson, MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-15-58 | | 22c. NAME OF CEMETERY OR CREMATORY Church Cemetery | | 22d. LOCATION (City, town, or county) (State) Chapel Hill, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 901 3rd St., S. W. | | | | 24a. REC'D BY REGISTRAR DATE 901 7-15-58 | | 24b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

| | | | | | | | |
|-----------------------|--|----------------------|--|-------------------------|--|--------------------------|--|
| DATE OF BIRTH | | PLACE OF BIRTH | | DATE OF DEATH | | PLACE OF DEATH | |
| JAN 1 1900 | | NEW YORK | | JAN 1 1900 | | NEW YORK | |
| SEX | | AGE | | CAUSE OF DEATH | | MANNER OF DEATH | |
| MALE | | 25 | | HEART DISEASE | | NATURAL | |
| OCCUPATION | | RESIDENCE | | EDUCATION | | RELIGION | |
| Clerk | | 1234 Main St | | High School | | Roman Catholic | |
| MARRIAGE | | SPOUSE | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | |
| None | | None | | None | | None | |
| PREVIOUS MARRIAGES | | PREVIOUS SPOUSES | | PREVIOUS DATES OF DEATH | | PREVIOUS PLACES OF DEATH | |
| None | | None | | None | | None | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF CLERK | |
| None | | None | | None | | None | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| None | | None | | None | | None | |
| PLACE OF SIGNATURE | | PLACE OF SIGNATURE | | PLACE OF SIGNATURE | | PLACE OF SIGNATURE | |
| None | | None | | None | | None | |
| OFFICIAL USE | | OFFICIAL USE | | OFFICIAL USE | | OFFICIAL USE | |
| None | | None | | None | | None | |
| DATE OF ENTRY | | DATE OF ENTRY | | DATE OF ENTRY | | DATE OF ENTRY | |
| None | | None | | None | | None | |
| PLACE OF ENTRY | | PLACE OF ENTRY | | PLACE OF ENTRY | | PLACE OF ENTRY | |
| None | | None | | None | | None | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8303 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08323

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Prince Geo.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cherry</u> | | c. LENGTH OF STAY IN 1b
<u>2 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>16 Mount Rainier</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Prince Georges Gen. Hosp</u> | | | | d. STREET ADDRESS
<u>4201 30th Street</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<u>Christopher Edwin Taylor</u> | | | | 4. DATE OF DEATH
Month <u>7</u> - Day <u>8</u> - Year <u>1958</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>10-10-52</u> | |
| 9. AGE (In years last birthday)
<u>6</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Edwin Hugh Taylor</u> | | | | 14. MOTHER'S MARRIAGE NAME
<u>Margaret D. Amato</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT
<u>Edwin H. Taylor, same address</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hemorrhage & shock</u>
<u>812X</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Massive laceration of liver & contusion of pancreas</u>
DUE TO
(c) <u> </u></p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u></p> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.
<input checked="" type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
<u>Struck by automobile while at play.</u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u>7:00</u> a.m. <u>7-5</u> p.m. <u>1958</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Highway</u> | | 20f. (City or town) (County) (State)
<u>Mount Rainier - Pr. Geo. Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John J. Maloney</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July-8, 1958</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>7/10/1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>East Lincoln</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Pr. George & Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John A. Mattingly</u> | | | | ADDRESS
<u>131-11th St</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Willie</u> | |
| | | | | DATE
<u>JUL 10 1958</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
1902 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

RESIDENCE

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Medical Examiner

Signature of Coroner

Signature of Juror

Signature of Witness

Signature of Physician

Signature of Nurse

Signature of Undertaker

Signature of Burial Officer

Signature of Registrar

Signature of Clerk

Signature of Treasurer

Signature of Auditor

Signature of Assessor

Signature of Collector

Signature of Marshal

Signature of Sheriff

Signature of Judge

Signature of District Attorney

Signature of County Attorney

Signature of City Attorney

Signature of Mayor

Signature of Councilman

Signature of Alderman

Signature of Common Council

Signature of Board of Health

Signature of Board of Education

Signature of Board of Trade

Signature of Board of Fire

Signature of Board of Police

Signature of Board of Public Works

Signature of Board of Public Safety

Signature of Board of Public Health

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8304

CERTIFICATE OF DEATH

08324

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chesley | | c. LENGTH OF STAY IN 1b
2 Hr 90 Min 15 | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville, | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Prince Georges General | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4. STREET ADDRESS
6010 43rd Avenue | |
| 3. NAME OF DECEASED (Type or print)
THOMAS, Harry P Thomas | | 4. DATE OF DEATH
Month July Day 10 Year 19 58 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1 / 21 / 89 |
| 9. AGE (In years last birthday)
69 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
Brother P. R. | |
| 11. BIRTHPLACE (State or foreign country)
D. C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S | |
| 13. FATHER'S NAME
CLINTON THOMAS | | 14. MOTHER'S MAIDEN NAME
JENNIE ASHDOWN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
6019-43-001 | |
| 17. INFORMANT
Nellie M. Thomas | | Address
6019-43-001 HYATTSVILLE MD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarct; Aortic Hypertrophy
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute urinary retention.
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
8 hours. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3-12 , 19 58 , to 7-10 , 19 58 , that I last saw the deceased alive on 7-10-58 , 19 58 , and that death occurred at M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
John P. Clum | | DATE SIGNED
7-10-58 | |
| PHYSICIAN'S NAME (Type)
John P. Clum | | ADDRESS (Street, city or town, state)
Hyattsville Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
July 14, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 22d. LOCATION (City, town, or county) (State)
Suitland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. W. Lees | | ADDRESS
Wash. D.C. | |
| 24a. REC'D BY REGISTRAR
301-44-58 | | 24b. REGISTRAR'S SIGNATURE
W. J. Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8305 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **08325**

FOR STATE
HEALTH DEPT.

M

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|--|----------------------------------|--|---|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Friendly | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | | | d. STREET ADDRESS
8451 Old Fort Road | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Charles Julian Thorne | | | | 4. DATE OF DEATH
Month July Day 15 Year 19 58 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 2, 1912 | | 9. AGE (In years last birthday)
45 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
Cunstruction | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Sidney Thorne | | | | 14. MOTHER'S MAIDEN NAME
Katie Taylor | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
W.W.2 578-09-2207 | | 17. INFORMANT
Stanley G. Thorne; same address as # 2. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute heart failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular disease
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John J. Maloney M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial July 17-58 | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Switland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Simmons Bros. 1661-44 Heper Rd S E | | | | 24a. REC'D BY REGISTRAR
DATE JUL 17 '58 | | 24b. REGISTRAR'S SIGNATURE
Alb. Lewis | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be retained as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

march 26 00

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--------------------------|--|---------------------------------|--|
| Name of Deceased | | Thorne, George | |
| Sex | | Male | |
| Age | | B.A.A. | |
| Date of Birth | | July 15, 1905 | |
| Place of Birth | | Maryland | |
| Usual Residence | | 1411 Old Port Road | |
| Cause of Death | | Thorne, George General Hospital | |
| Date of Death | | July 15, 1958 | |
| Time of Death | | 10:30 P.M. | |
| Place of Death | | Thorne, George General Hospital | |
| Physician | | Thorne, George | |
| Manner of Death | | Natural | |
| Disease | | Cerebral Thrombosis | |
| Organ or System Affected | | Cerebral Thrombosis | |
| Anatomical Description | | Cerebral Thrombosis | |
| Toxicology | | None | |
| Alcohol | | None | |
| Drugs | | None | |
| Infectious Disease | | None | |
| Contagious Disease | | None | |
| Injury | | None | |
| Poison | | None | |
| Other | | None | |
| Signature of Examiner | | John E. McManey, M.D. | |
| Date | | July 15, 1958 | |
| Place | | Baltimore, Maryland | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08326

8334

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>DR. Geo's Co.</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>DR. Geo's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silesia</u> | | c. LENGTH OF STAY IN 1b <u>38 yrs</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silesia</u> | | d. STREET ADDRESS <u>7851-Livingston Rd SE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7851-Livingston Rd SE</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>MARIE J. TILCH</u> | | 4. DATE OF DEATH <u>July 3rd 1958</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-march 1893</u> |
| 9. AGE (In years lost birthday) <u>65</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George T. Underwood</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine Blandford</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Robert Tilch Same #2</u> | | Address | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>
<u>443X</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 hours</u>
<u>8 years</u> |
|---|--|--|

| | | |
|---|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|---|--|---|

| | | | |
|--|--|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |

21. I certify that I attended the deceased from July 3, 1958, to July 3, 1958, that I last saw the deceased alive on July 3, 1958, and that death occurred at 7:30 M, from the causes and on the date stated above.

| | | |
|--|--------------------------------|---------------------------|
| ACTUAL SIGNATURE <u>Herbert Wisotsky</u> | M.D. <u>101 ANDREY LANE SE</u> | DATE SIGNED <u>7/3/58</u> |
| PHYSICIAN'S NAME (Type) <u>HERBERT WISOTSKY M.D.</u> | | <u>WASH DC</u> |

| | | | |
|---|------------------------------------|---|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>July 5-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u> | 22d. LOCATION (City, town, or county) (State) <u>Piscataway Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Bros</u> | | ADDRESS <u>1661-9th Hyatt</u> | 24a. REC'D BY REGISTRAR <u>DATE JUL 7 '58</u> |
| | | 24b. REGISTRAR'S SIGNATURE <u>Robert Tilch</u> | |

CERTIFICATE OF DEATH

8834

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED
<i>John Doe</i> | | 2. SEX
<i>Male</i> | | 3. AGE
<i>45</i> | | 4. DATE OF DEATH
<i>Jan 15 1918</i> | | 5. PLACE OF DEATH
<i>Home</i> | |
| 6. OCCUPATION
<i>Teacher</i> | | 7. CAUSE OF DEATH
<i>Heart Disease</i> | | 8. MANNER OF DEATH
<i>Natural</i> | | 9. SIGNATURE OF PHYSICIAN
<i>J. H. Smith</i> | | 10. SIGNATURE OF REGISTRAR
<i>W. B. Jones</i> | |
| 11. SIGNATURE OF NEXT OF KIN
<i>Mary Doe</i> | | 12. SIGNATURE OF MINISTER OF THE GOSPEL
<i>Rev. J. K. Brown</i> | | 13. SIGNATURE OF CLERGYMAN
<i>Rev. J. K. Brown</i> | | 14. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 15. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | |
| 16. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 17. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 18. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 19. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 20. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | |
| 21. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 22. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 23. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 24. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 25. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | |
| 26. SIGNATURE OF CHURCH CLERK
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<i>Rev. J. K. Brown</i> | | 28. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 29. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 30. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | |
| 31. SIGNATURE OF CHURCH CLERK
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<i>Rev. J. K. Brown</i> | | 33. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 34. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 35. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | |
| 36. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 37. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 38. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 39. SIGNATURE OF CHURCH CLERK
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<i>Rev. J. K. Brown</i> | |
| 41. SIGNATURE OF CHURCH CLERK
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<i>Rev. J. K. Brown</i> | | 43. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 44. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 45. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | |
| 46. SIGNATURE OF CHURCH CLERK
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<i>Rev. J. K. Brown</i> | | 48. SIGNATURE OF CHURCH CLERK
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| 51. SIGNATURE OF CHURCH CLERK
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| 56. SIGNATURE OF CHURCH CLERK
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| 61. SIGNATURE OF CHURCH CLERK
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<i>Rev. J. K. Brown</i> | | 74. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 75. SIGNATURE OF CHURCH CLERK
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<i>Rev. J. K. Brown</i> | | 80. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | |
| 81. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 82. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 83. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 84. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 85. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | |
| 86. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 87. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 88. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 89. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 90. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | |
| 91. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 92. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 93. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 94. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 95. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | |
| 96. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 97. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 98. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 99. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | | 100. SIGNATURE OF CHURCH CLERK
<i>Rev. J. K. Brown</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08327

8306

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverley Md. | | c. LENGTH OF STAY IN 1b 5 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Ralph J. Vendemia | | 4. DATE OF DEATH July 28 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/2/08 |
| 9. AGE (In years lost birthday) 50 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber | | 10b. KIND OF BUSINESS OR INDUSTRY Barber Shop | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? United States | |
| 13. FATHER'S NAME Frank Vendemia | | 14. MOTHER'S MAIDEN NAME Agatina Bruce | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown | | 16. SOCIAL SECURITY NO. 577-03-9359 | |
| 17. INFORMANT Charlotte Vandemia | | 18. ADDRESS Wife Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 48 hr.
5 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary occlusion 5 yrs ago | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 23 to July 28 , 19 58 , that I last saw the deceased alive on July 28 , 19 58 , and that death occurred at 3:25 P. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 3404 Cheverley Ave. Cheverley Md. DATE SIGNED 7/28/58 | | | |
| ACTUAL SIGNATURE John Keboe M.D. | | PHYSICIAN'S NAME (Type) JOHN KEBOE | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/31/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY George Washington Riggs Rd. Hyattsville, Md. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home, Inc. | | 24a. REG'D BY REGISTRAR AUG 1 1958 | |
| 24b. REGISTRAR'S SIGNATURE | | 24c. REGISTRAR'S SIGNATURE | |

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED JOHN W. WILSON SEX M AGE 65 DATE OF BIRTH 1880
 PLACE OF BIRTH W. Va. COUNTY Putnam MARITAL STATUS Married
 DECEASED AT HOME Yes PLACE OF DEATH Home DATE OF DEATH 1945

CAUSE OF DEATH Heart Disease Myocardial Infarction
 INTERVIEWED BY Dr. J. H. Smith DATE 10/15/45

REPORTED BY John W. Wilson RELATIONSHIP Wife
 SIGNATURE OF REPORTER [Signature] DATE 10/15/45

DECEASED'S SIGNATURE [Signature] DATE 10/15/45

DECEASED'S ADDRESS 123 Main St., Putnam Co., W. Va.

DECEASED'S OCCUPATION Farmer

DECEASED'S EDUCATION High School

DECEASED'S RELIGION Methodist

DECEASED'S RACE White

DECEASED'S COLOR White

DECEASED'S SEX Male

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08328

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Dist. of Col. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3 | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
Isaac William Welsh | | | | 4. DATE OF DEATH Month Day Year
July 11 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Col. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-20-08 | |
| 9. AGE (In years last birthday) 50 yrs. | | 10. IF UNDER 1 YEAR Months Days | | 11. IF UNDER 24 HRS. Hours Min. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man | | | | 10b. KIND OF BUSINESS OR INDUSTRY Real Estate | | | |
| 11. BIRTHPLACE (State or foreign country) Arkansas | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Willie Welsh | | | | 14. MOTHER'S MAIDEN NAME Savannah Nelson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Alice Welsh; same address as No. 2. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 443x Acute congestive heart failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease
DUE TO (c)</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John T. Maloney | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 7-17-58 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial | | | | 22d. LOCATION (City, town, or county) (State) Suitland, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. Ernest Jarvis | | | | 24a. REC'D BY REGISTRAR JUL 17 '58 | | | |
| ADDRESS 1432 You St. N.W. Washington D.C. | | | | 24b. REGISTRAR'S SIGNATURE Alfred... | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be retained as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1907

STATE OF MASSACHUSETTS

27-10-06

Overly

Massachusetts General Hospital

100 State Street

11

July

1906

1-20-06

1-20-06

1-20-06

U.S.A.

Massachusetts

State of Massachusetts

Department of Health

William H. H. H.

Governor

Active Member; new subject to No. 1.

Active negative heart failure

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

Spontaneous cardiovascular disease

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8335 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08329

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

| | | | | | |
|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheltenham</u> week | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheltenham</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Van Brody Road</u> | | | d. STREET ADDRESS <u>Van Brody Road</u> | | |
| 3. NAME OF DECEASED (Type or print) <u>Sheild Ann West</u> | | | 4. DATE OF DEATH <u>July 6 1958</u> | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Colored</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>June 25, 1958</u> | | 9. AGE (in years last birthday) <u>11</u> yrs. | | 10. IF UNDER 1 YEAR <u>11</u> Months <u>11</u> Days <u>11</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. - a</u> | | |
| 13. FATHER'S NAME <u>Thomas Arthur West</u> | | | 14. MOTHER'S MAIDEN NAME <u>Pauline Catherine Savoy</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> | | | 16. SOCIAL SECURITY NO. <u>—</u> | | |
| 17. INFORMANT <u>Thomas West, same as #2</u> | | | Address <u>—</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Toxemia</u>
 <u>763.0</u> DUE TO
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchopneumonia</u>
 DUE TO (c) <u>—</u></p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>James I. Boyd</u> M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | DATE SIGNED <u>July 6, 1958</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7/8/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Rosaryville, Md.</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Wash D.C., Md.</u> | | | |
| 24a. REC'D BY REGISTRAR <u>—</u> | | | 24b. REGISTRAR'S SIGNATURE <u>—</u> | | |

2077214XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Baltimore Health Department, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8336

CERTIFICATE OF DEATH

Reg. Dist. No.

08330

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Clinton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Clinton, Maryland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
RFD. # 3, Box. 335. | | d. STREET ADDRESS
RFD. # 3, Box. 335 | |
| e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
LEE First Middle Last WHITE | | 4. DATE OF DEATH
Month July Day 31st. Year 19 58 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 7- 1875 |
| 9. AGE (In years last birthday)
82 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Truck Farmer | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Lawrence Ray White Address Same # 2. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Death Coronary Occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Atherosclerosis DUE TO
(c) unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Natural Causes | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July 16, 1958 , to July 31, 1958 , that I last saw the deceased alive on July 29, 1958 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 5440 - Silver Hill Road S. E. Washington 28, D. C. DATE SIGNED 7/31/ 58 | | | |
| ACTUAL SIGNATURE Paul C. Van Natta M.D. | | | |
| PHYSICIAN'S NAME (Type) PAUL C. VAN NATTA | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
August 2-58 | 22c. NAME OF CEMETERY OR CREMATORY
Bells Cemetery | 22d. LOCATION (City, town, or county) (State)
Camp Springs, Maryland. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Simmons Brothers ADDRESS 1661- Good Hope Rd. SE Washington 20, D.C. | | 24a. REC'D BY REGISTRAR
DATE AUG 4 '58 | 24b. REGISTRAR'S SIGNATURE
W. H. Johnson |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8337

CERTIFICATE OF DEATH

Reg. Dist. No.

08331

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Park</u> | | | | c. LENGTH OF STAY IN 1b <u>15 months</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural (Bradbury Park)</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4626 Porter Avenue, Washington</u> | | | | d. STREET ADDRESS <u>4626 Porter Ave, Washington</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Theodore Christian Wilde</u> | | | | 4. DATE OF DEATH <u>July 9, 1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 26, 1896</u> | |
| 9. AGE (In years last birthday) <u>62</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army Finance Dept.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Hoboken, New Jersey</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S. of A.</u> | |
| 13. FATHER'S NAME <u>Reinhold Carl WILDE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Amanda Hendricks</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes (3x)</u> | | 16. SOCIAL SECURITY NO. <u>10-15-1923 to 10-9-1926</u> | | 17. INFORMANT <u>Mrs. Ida Grubb</u> | | Address <u>4626 Porter Ave. Washington 23, D.C.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Failure & Cerebral Thrombosis</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Ht Disease</u>
DUE TO (c) <u>Arteriosclerosis Generalized</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour, 1 wk.</u>
<u>? Years</u>
<u>? Years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>343X Encephalitis contracted in Philippine Islands</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>July 2, 1958</u> , to <u>July 9, 1958</u> , that I last saw the deceased alive on <u>July 2, 1958</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Walcott W. Gibson</u> | | | | ADDRESS (Street, city or town, state) <u>2412 Minnesota Ave. S.E.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Walcott W. GIBSON</u> | | | | DATE SIGNED <u>Washington 20, D.C.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7-14-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Chambers Co. Washington, D.C.</u> | | | | 24a. REC'D BY REGISTRAR <u>JUL 14 58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. Chambers</u> | |

CERTIFICATE OF DEATH

2123

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| NAME OF DECEASED
<i>John A. Smith</i> | | AGE
<i>45</i> | | SEX
<i>Male</i> | | RACE
<i>White</i> | |
| DATE OF DEATH
<i>Jan 15 1910</i> | | PLACE OF DEATH
<i>Home</i> | | CITY
<i>Baltimore</i> | | COUNTY
<i>Harford</i> | |
| CAUSE OF DEATH
<i>Heart Disease</i> | | MANNER OF DEATH
<i>Natural</i> | | OCCUPATION
<i>Teacher</i> | | EDUCATION
<i>High School</i> | |
| SIGNATURE OF PHYSICIAN
<i>Dr. J. H. Jones</i> | | SIGNATURE OF MINISTER
<i>Rev. W. B. Clark</i> | | SIGNATURE OF CORONER
<i>John D. Brown</i> | | SIGNATURE OF JURY
<i>John A. Smith</i> | |
| DATE OF BURIAL
<i>Jan 17 1910</i> | | PLACE OF BURIAL
<i>St. Paul's Church</i> | | CITY
<i>Baltimore</i> | | COUNTY
<i>Harford</i> | |
| SIGNATURE OF BURIAL OFFICER
<i>John D. Brown</i> | | SIGNATURE OF MINISTER
<i>Rev. W. B. Clark</i> | | SIGNATURE OF CORONER
<i>John D. Brown</i> | | SIGNATURE OF JURY
<i>John A. Smith</i> | |

RECEIVED
JAN 15 1910
BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8338 CERTIFICATE OF DEATH

08332

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hillcrest Hts AAFB</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>X Hillcrest Hts, AFB</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
<u>1001 ST USAF HOSP</u> | | | | d. STREET ADDRESS
<u>5739 26th Ave S.E.</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Catherine</u> Middle <u>MARGARET</u> Last <u>Williams</u> | | | | 4. DATE OF DEATH
Month <u>19</u> Day <u>July</u> Year <u>1958</u> | | | |
| 5. SEX
<u>F</u> | | 6. COLOR OR RACE
<u>CAU</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>DEC. 2 1915</u> | |
| 9. AGE (In years last birthday)
<u>42</u> yrs. | | IF UNDER 1 YEAR
Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> | | IF UNDER 24 HRS.
Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>NONE</u> | | 11. BIRTHPLACE (State or foreign country)
<u>LONDON, ENGLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>HERBERT BERNARD</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>ELLEN - UNKNOWN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>—</u> | | 16. SOCIAL SECURITY NO.
<u>UNKNOWN</u> | | 17. INFORMANT
<u>HUSBAND</u> Address <u>2739-26th Ave SE, Hillcrest Hts, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>bronchopneumonia, plural effusions</u>
DUE TO <u>acute, malnutrition</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma, primary in st. breast</u>
(c) <u>with gross abdominal metastases</u>
INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs.</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>5 JULY, 1958</u> , to <u>19 JUL, 1958</u> , that I last saw the deceased alive on <u>19 July, 1958</u> , and that death occurred at <u>6:45 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>E. Edward J. Smith</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>1001 ST USAF HOSPITAL</u> DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) <u>EDWARD J. Smith, CAPT USAF (MC)</u> | | | | <u>ANDREWS AF BASE, WASH. 25, D.C.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>7-20-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Johnston, Penna.</u> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W. W. Chamber Co. Inc.</u> | | | | ADDRESS
<u>517-11th St. S.E.</u> | | 24a. RECEIVED BY REGISTRAR
DATE <u>JUL 22 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>W. W. Chamber</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the official transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE

19 JULY 1958: I certify that PRINCE GEORGES COUNTY
CORNER WAS CONTACTED AND CLEARENCE WAS GRANTED TO
MOVE BODY TO CHAMBERS FUNERAL HOME, WASH. D. C.
AND FURTHER TO WEEKS FUNERAL HOME, OHIO STREET,
JOHNSTOWN, PENNA. FOR BURIAL.

Charles W. Debut ^{W/SGT}
NCO D - 19 July 58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08333
Reg. Dist. No.

8308

FOR STATE
HEALTH DEPT.

| | | | | | |
|---|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
D.O.A. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Suitland | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | | e. STREET ADDRESS
4715 1/2 Summer Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
Luther Warren Williams | First | Middle | Last | 4. DATE OF DEATH
July 24, 1958 | Month |
| 5. SEX
Male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 16, 1920 | 9. AGE (In years last birthday)
37 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Truckdriver | | 10b. KIND OF BUSINESS OR INDUSTRY
Oil Co. Suitland. District of Columbia | | 11. BIRTHPLACE (State or foreign country)
U.S.A. | |
| 13. FATHER'S NAME
Herbert Reiley | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Huber | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Elizabeth Williams; same address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
434.1 IMMEDIATE CAUSE (a) Congestive heart failure
DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause lost. (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town)
Suitland | (County)
Maryland | (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
<i>John T. Maloney</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type)
John T. Maloney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
July 26, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | |
| 22d. LOCATION (City, town, or county)
Suitland | | (State)
Maryland | | 22e. REC'D BY REGISTRAR
July 28 '58 | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. W. CHAMBERS CO. S.E., Wash., D.C. | | 24. REGISTRAR'S SIGNATURE
<i>W. W. Chambers</i> | | 24b. REGISTRAR'S SIGNATURE | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1902

FOR STATE

DEPARTMENT OF HEALTH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be retained as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8309

08334

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b D.O.A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Wallace Edward Williams | | 4. DATE OF DEATH July 19, 1958 | |
| 5. SEX Male | | 6. COLOR OR RACE colored | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-17-1883 | |
| 9. AGE (In years and birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired plasterer | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Williams | | 14. MOTHER'S MAIDEN NAME Harriet Frazier | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Address Hosp. Records and Mary Murray; address same | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease
DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John T. Maloney | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED July 20, 1958 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-24-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Thaddeus | | 22d. LOCATION (City, town, or county) (State) Washington D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Froguis Funeral Home 389 R L | | 24a. REC'D BY REGISTRAR JUL 23 '58 | |
| 24b. REGISTRAR'S SIGNATURE | | 24c. REGISTRAR'S SIGNATURE | |

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6000

FOR STATE
HEALTH DEPT

MASSACHUSETTS
STATE DEPARTMENT OF
HEALTH - BOSTON

| | | | | | |
|-------------------------------|--|----------------------|--|-------------------------|--|
| Name of Deceased | | Sex | | Age | |
| Date of Death | | Time of Death | | Place of Death | |
| Cause of Death | | Manner of Death | | Occupation | |
| Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | |
| Date of Report | | Time of Report | | Place of Report | |
| Signature of Physician | | Signature of Nurse | | Signature of Hospital | |
| Signature of Family | | Signature of Friends | | Signature of Community | |
| Signature of Church | | Signature of School | | Signature of Government | |
| Signature of Other | | Signature of Other | | Signature of Other | |

CERTIFICATE OF DEATH

Reg. Dist. No.

8310

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Alabama
b. COUNTY Cranshaw | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Laurel | | c. LENGTH OF STAY IN 1b
40X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Laurel General Hospital, Inc. | | d. STREET ADDRESS
Rt. 2 | |
| 3. NAME OF DECEASED (Type or print)
First Baby Middle Boy Last Grover Anthony Williamson | | 4. DATE OF DEATH
Month July Day 28 Year 19 58 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 28, 1958 |
| 9. AGE (In years last birthday) yrs.
5 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | 10b. KIND OF BUSINESS OR INDUSTRY
none | |
| 11. BIRTHPLACE (State or foreign country)
Laurel Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Grover W. Williamson | | 14. MOTHER'S MAIDEN NAME
Cora Sue Atwell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
_____ | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Standstill
7545 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity
DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
5 hrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 28 , 19 58 , to July 28 , 19 58 , that I last saw the deceased alive on July 28 , 19 58 , and that death occurred at 330P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Thomas R. Mazzacco M.D. | | ADDRESS (Street, city or town, state)
320 Montgomery St., Laurel, Maryland | |
| PHYSICIAN'S NAME (Type)
Thomas R. Mazzacco, M. D. | | DATE SIGNED
7-28-58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
July 28, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Long Hill Cem. | | 22d. LOCATION (City, town, or county) (State)
Laurel Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
De Witt Donaldson | | ADDRESS
Laurel, Md. | |
| 24a. REC'D BY REGISTRAR
JUL 31 '58 | | 24b. REGISTRAR'S SIGNATURE
W. Search | |

2083182XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the death-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8339

CERTIFICATE OF DEATH

Reg. Dist. No.

08336

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland. b. COUNTY Pr. Geo's Co. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Upper Marlboro | | | | c. LENGTH OF STAY IN 1b
2 Years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Upper Marlboro | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
R.F.D. # 1, Box. 306 | | | | d. STREET ADDRESS
R.F.D. # 1, Box. 306 | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) STELLA ANN WOODS | | | | 4. DATE OF DEATH July 30th. 19 58 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 8th. 1885 | |
| 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
West Va | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
William A. Hutcherson | | | | 14. MOTHER'S MAIDEN NAME
Barbara Steiner | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Helen E. Moore Address Same # 2. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 442X DUE TO Conjunctive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Vascular DUE TO Proneal Disease (c) 6 gm | | | | INTERVAL BETWEEN ONSET AND DEATH
3 months | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | | | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 11, 1958 to July 30, 1958 , that I last saw the deceased alive on July 24, 1958 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James E. Sasser M.D. | | | | DATE SIGNED Upper Marlboro | | | |
| PHYSICIAN'S NAME (Type) James E. Sasser M.D. | | | | Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Aug 15 58 | | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 22d. LOCATION (City, town, or county) (State)
Suitland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Simmons Bros | | | | ADDRESS
1661-good Hope Rd | | 24a. REC'D BY REGISTRAR
AUG 1 '58 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE
Chadwick | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be kept as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8238

08337

Reg. Dist. No.

| | | | | | |
|--|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
College Park | | c. LENGTH OF STAY IN lb
5 years | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
College Park | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
9004 48th Place | | | d. STREET ADDRESS
9004 48th Place | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
Chester Leroy Yates | | | 4. DATE OF DEATH
Month July Day 8 Year 1958 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 31, 1909 | | 9. AGE (in years last birthday)
48 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Delivery Man | | 10b. KIND OF BUSINESS OR INDUSTRY
Furniture | 11. BIRTHPLACE (State or foreign country)
W. Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Ben Yates | | | 14. MOTHER'S MAIDEN NAME
Hattie Murphy | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
Eleanor Yates; same address as # 2. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carbon monoxide poisoning
DUE TO
(c) Smouldering bed cloths. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Asphyxiated by fumes in room caused by smouldering bed cloths. | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour 7-8-58 19
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | |
| | | | | 20f. (City or town) (County) (State)
College Park, Pr. Geo. Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
John T. Maloney | | M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
7-8-58 | |
| EXAMINER'S NAME (Type)
John T. Maloney, M.D. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7/11/58 | | 22c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | |
| | | | | 22d. LOCATION (City, town, or county) (State)
Colmar Manor, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
F. Gasch's Sons | | | ADDRESS
Hyattsville, Md. | | 24a. REC'D BY REGISTRAR
DATE JUL 11 '58 |
| | | | | | 24b. REGISTRAR'S SIGNATURE
W. J. Seach |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8340 **CERTIFICATE OF DEATH** **08338**
Reg. Dist. No.

| | | | |
|---|----------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Pr. George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D.C. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Carroll Manor | | d. STREET ADDRESS 4012 - 1st Pl. S.W. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Anna First R Middle Zinke Last | | 4. DATE OF DEATH July 4th. 1958 19 | |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCT. 11, 1879 |
| 9. AGE (In years last birthday) 78 yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | 10b. KIND OF BUSINESS OR INDUSTRY at home | |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME John Rippe | | 14. MOTHER'S MAIDEN NAME Mary Jane McGuire | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Dorothea Leppert- | | Address 4012 - 1st Pl. S.W. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 36 hr.
20 yr. + | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Congestive Heart Failure | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 1, 1958 , to July 4, 1958 , that I last saw the deceased alive on July 4, 1958 , and that death occurred at 11:30 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Habeeb Bacchus | | ADDRESS (Street, city or town, state) 8602 Farrell Ct | |
| PHYSICIAN'S NAME (Type) HABEEB BACCHUS | | DATE SIGNED 7/4/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-11-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Vale | | 22d. LOCATION (City, town, or county) (State) Schenectady N.Y. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - 300 - 4th St N.E. D.C. | | 24a. REC'D BY REGISTRAR JUL 7 '58 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE Alfred | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|------------------|--|-------------|--|------------------|--|-------------------|--|------------------|--|-------------------|--|----------------------------|--|------------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of birth | | 5. Place of birth | | 6. Date of death | | 7. Place of death | | 8. Cause of death | | 9. Manner of death | | 10. Signature of physician | | 11. Signature of registrar | | 12. Date of registration | |
| John Doe | | Male | | 45 | | Jan 1, 1920 | | Baltimore, Md | | Jan 15, 1965 | | Baltimore, Md | | Heart Disease | | Natural | | [Signature] | | [Signature] | | Jan 20, 1965 | |
| 13. Name of informant | | 14. Relationship | | 15. Address | | 16. City | | 17. State | | 18. Zip | | 19. Telephone | | 20. Signature of informant | | 21. Date of completion | | 22. Registrar's stamp | | 23. Seal of Registrar | | 24. Remarks | |
| Jane Doe | | Wife | | 123 Main St | | Baltimore | | Md | | 21201 | | (410) 555-1234 | | [Signature] | | Jan 20, 1965 | | [Stamp] | | [Seal] | | | |



NOTED IN THE
OFFICE OF THE
REGISTRAR